DOCUMENT RESUME

ED 277 501 RC 016 015

TITLE Native American Children, Youth, and Families. Part 3. Hearing before the Select Committee on Children, Youth, and Families. House of Representatives, Ninety-Ninth Congress, Second Session (Albuquerque, NM, January 10, 1986).

INSTITUTION Congress of the U.S., Washington, DC. House Select Committee on Children, Youth, and Families.

PUB DATE 86

NOTE 293p.; Sections of document contain small type. For Parts 1 and 2, see RC 016 013-014.

AVAILABLE FROM Superintendent of Document, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.

PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.

DESCRIPTORS American Indian Education; American Indian Reservations; *American Indians; *Child Welfare; *Community Problems; *Drug Abuse; Drug Rehabilitation; *Economically Disadvantaged; Economic Climate; Elementary Secondary Education; *Family Problems; Females; Health Conditions; Hearings; Prevention; Rehabilitation Programs; Reservation American Indians; Suicide; Tribes; Unemployment; Youth Programs

IDENTIFIERS Colorado; Congress 99th; Fetal Alcohol Syndrome; Navajo (Nation); New Mexico; Pueblo (People); Ute (Tribe)

ABSTRACT

As part of a weeklong investigation into conditions among Native American families and children, the House of Representatives Select Committee on Children, Youth, and Families met to hear testimony from tribal leaders, parents, young adults, and service providers from reservations and pueblos in New Mexico and Colorado. Topics include unemployment and its effect on the family; housing, sewer, and electricity shortages; a tribally-run school that acts as a base for a comprehensive array of youth and adult services; and foster care and child welfare services. Numerous speakers address the link between alcohol abuse and family problems including Fetal Alcohol Syndrome. Teen-age students from the Southern Ute Tribe (Colorado) discuss a program they initiated to encourage fellow students to remain drug and alcohol free. The report includes transcription of the hearing proceedings, numerous prepared statements from tribal organizations, and articles on issues such as adolescent suicide at an Indian reservation, health of Native American women, childhood injuries in a Native American community, and the epidemiology of Fetal Alcohol Syndrome among American Indians of the Southwest. (JHZ)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED277501

NATIVE AMERICAN CHILDREN, YOUTH, AND FAMILIES

Part 3

DEC 1986
RECEIVED
ERIC/CRESS

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

HEARING HELD IN ALBUQUERQUE, NM, JANUARY 10, 1986

Printed for the use of the
Select Committee on Children, Youth, and Families

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

U.S. GOVERNMENT PRINTING OFFICE

61-183 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

RC016015

BEST COPY AVAILABLE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

GEORGE MILLER, California, *Chairman*

WILLIAM LEHMAN, Florida
PATRICIA SCHROEDER, Colorado
LINDY BOGGS, Louisiana
MATTHEW F. McHUGH, New York
TED WEISS, New York
BERYL ANTHONY, JR., Arkansas
BARBARA BOXER, California
SANDER M. LEVIN, Michigan
BRUCE A. MORRISON, Connecticut
J. ROY ROWLAND, Georgia
GERRY SIKORSKI, Minnesota
ALAN WHEAT, Missouri
MATTHEW G. MARTINEZ, California
LANE EVANS, Illinois

DAN COATS, Indiana
HAMILTON FISH, JR., New York
THOMAS J. BLILEY, JR., Virginia
FRANK R. WOLF, Virginia
DAN BURTON, Indiana
NANCY L. JOHNSON, Connecticut
JOHN R. McKERNAN, JR., Maine
BARBARA F. VUCANOVICH, Nevada
DAVID S. MONSON, Utah
ROBERT C. SMITH, New Hampshire

COMMITTEE STAFF

ALAN J. STONE, *Staff Director and Counsel*
ANN ROSEWATER, *Deputy Staff Director*
MARK SOUDER, *Minority Staff Director*

BEST COPY AVAILABLE

CONTENTS

	Page
Hearing held in Albuquerque, NM, on January 10, 1986	1
Statement of:	
Bronson, Melinda, director, Tribal Social Services, Ute Mountain Tribe, Towaoc, CO	78
Cohoe, Bennie, executive director, Ramah Navajo School Board, Inc., Pine Hill, NM	73
Estevan, William, First Lieutenant Governor, Pueblo of Acoma, NM	67
Hernandez, Francisca, executive director, Albuquerque Area Indian Health Board, accompanied by Ona Lara Porter, director of planning, Albuquerque Area Indian Health Board	20
Martorelli, Toni, director, Governor's office on children and youth, Santa Fe, NM	13
May, Philip, associate professor of sociology, University of New Mexico, Albuquerque, NM	17
Monte, Danielle, drug buster, Southern Ute Tribe, CO	6
Paytiamo, Stanley, Governor, Pueblo of Acoma, NM	64
Pena, Gilbert, chairman, All Indian Pueblo Council, Albuquerque, NM	4
Rael, Toni, drug buster, Southern Ute Tribe; accompanied by Sue Velasquez, VISTA volunteer, Ignacio, CO	6
Reyna, Marjorie, executive director, division of economic development, Navajo Nation, Window Rock, AZ	68
Solomon, Floyd, parent and parent trainer, Education for parents of Indian children with special needs, Laguna Pueblo, NM	62
Prepared statements, letters, supplemental materials, etc.:	
Baker, Chris A., chairman, Southern Ute Indian Tribal Council, prepared statement of	107
Bird, Rev. Henry L., Socorro, NM, the Episcopal Diocese of the Rio Grande, Urban Indian Ministry, letter to Chairman George Miller, dated Jan. 12, 1986	267
Bronson, Melinda, MSW, ACSW, director, Tribal Social Services, Ute Mountain Ute Tribe, Towaoc, CO, prepared statement of	81
Cohoe, Bennie, executive director, Ramah Navajo School Board, Inc., CPO Drawer A, Pine Hill, NM:	
Prepared statement of	76
Addenda to prepared statement	113
Davis, Sally, M.Ed., instructor and director, Community/School-Health, Department of Pediatrics, University of New Mexico, Albuquerque, NM, Ken Hunt, B.S. coordinator, School-based Adolescent Health Programs, Department of Pediatrics, University of New Mexico, Albuquerque, NM	173
DeVaney, Joyce, MPH Adolescent Health, New Mexico Health and Environment Department, Health Services Division, Santa Fe, NM, letter to Chairman George Miller, dated Jan. 7, 1986, enclosing abstract of the Native American adolescent injury prevention project	265
Dodd, Dottie, prevention coordinator, Southern Ute Community Action Programs, Alcoholism Center, Ignacio, CO:	
"Ignacio Drug Busters," pamphlet entitled	10
"Ignacio Youths to Run Against Drugs," newspaper article entitled	12
Letter to Chairman George Miller, dated January 1986	8
French, Roy, principal, Taos Day School, Taos, NM, letter to Chairman George Miller, dated Jan. 15, 1986	105
Hernandez, Francisca, executive director, and Ona Lara Porter, director, Planning and Community Development:	
Additional statement of	44

BEST COPY AVAILABLE

Prepared statements, letters, supplemental materials, etc.—Continued Page
Hernandez, Francisca, executive director, and Ona Lara Porter, director, Planning and Community Development—Continued
Prepared statement of ... 25
Kitzes, Judith A., M.D., MPH, and Lawrence R. Berger, M.D., MPH:
"Childhood Injuries in a Native American Community," article entitled ... 252
"The Health of Native American Women," article entitled ... 214
Martorelli, Toni, director of Governor's office on children and youth, prepared statement of ... 15
May, Philip A., Ph.D., associate professor of sociology, University of New Mexico, Albuquerque, NM:
"A Pilot Project on Fetal Alcohol Syndrome Among American Indians," from Alcohol Health & Research World, vol. 7, No. 2, winter 1982/83, article entitled ... 195
"Adolescent Suicide at an Indian Reservation," article entitled ... 203
"Epidemiology of Fetal Alcohol Syndrome Among American Indians of the Southwest," article entitled ... 181
Prepared statement of ... 20
"Suicide and the American Indian," article entitled ... 210
Miller, Hon. George, a Representative in Congress from the State of California, and chairman, Select Committee on Children, Youth, and Families:
Letter to Floyd R. Solomon, from Chairman George Miller, requesting information ... 88
Opening statement of ... 3
Monte, Danielle, member of the Southern Ute Tribe, Ignacio, CO, prepared statement of ... 6
Paytiamo, Gov. Stanley, Governor of the Pueblo of Acoma, Albuquerque, NM, prepared statement of ... 66
Pena, Gilbert M., chairman, All Indian Pueblo Council, Inc., Albuquerque, NM, prepared statement of ... 5
Pueblo of Laguna, The Laguna Project Charlie Committee, Laguna Service Center, Laguna, NM, with appendixes ... 270
Reyna, Marjorie, executive director for the Navajo division of economic development, the Navajo Tribe, Window Rock, AZ, prepared statement of ... 71
Sanchez, Gilbert J., chairman, Board of Governors, Eight Northern Indian Pueblos Council, Santa Fe, NM, letter to Chairman George Miller, dated Jan. 30, 1986, with enclosures ... 92
Solomon, Floyd, parent and parent trainer, education for parents of Indian children with special needs, Laguna Pueblo, NM:
Prepared statement of ... 63
Response to questions posed by Chairman George Miller ... 88

BEST COPY AVAILABLE

NATIVE AMERICAN CHILDREN, YOUTH, AND FAMILIES

Part 3

FRIDAY, JANUARY 10, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Albuquerque, NM.

The committee met, pursuant to notice, at 9:15 a.m. at the Indian Pueblo Cultural Center Albuquerque, NM, Hon. George Miller (chairman of the committee) presiding.

Members present: Representatives Miller, Lehman, and Wheat.

Staff present: Jill Kagan, professional staff; Judy Weiss, professional staff; and Mark Souder, minority staff director.

Chairman MILLER. Good morning. The Select Committee On Children, Youth, and Families will come to order. I want to welcome everybody to the hearing this morning. I'm Congressman George Miller, chairman of the select committee. I will soon be joined by Congressman Bill Lehman, of Florida, and Congressman Alan Wheat, of Missouri.

This morning's hearing is the last in our week-long investigation into conditions among Native American families and children. This week we visited communities and held hearings in the Northwest, then traveled to the Navajo and Papago Reservations in Arizona. Yesterday we heard from providers and tribal leaders during our visit to the Gila River Indian Community.

We are pleased to be in Albuquerque today and look forward to receiving testimony from tribal leaders, parents, young adults, and providers from reservations and pueblos in New Mexico and Colorado.

We will conclude this afternoon with a site visit to the Laguna Pueblo. We will get a chance to visit a model program for teens which focuses on preventing many of the problems which confront Native American families.

The record that we have created already this week enlarges substantially our knowledge of children and family issues within the Native American community.

This morning we will further expand that record. We will get a first-hand report on unemployment and its effects on the family and learn about housing, sewer, and electricity shortages. We will also learn about a tribally run school which acts as a base for a comprehensive array of youth and adult services. We will see how foster care and child welfare services are working.

Once again we will receive testimony on the link between alcohol abuse and severe family-related problems, including Fetal Alcohol Syndrome. We will learn about a comprehensive, community-based alcoholism prevention program, as well as a program which students have begun on their own to encourage other students to remain drug and alcohol free.

I am looking forward to our hearing and our site visit. Your testimony will become part of the record of the U.S. Congress.

Our committee has pledged to care about all children and families in America, to listen and to look for gaps in services and to learn from positive, successful programs. That is why we are here today, and we deeply appreciate the hospitality of everyone who has been so helpful in setting up this hearing.

I would just like to expand on this and say that I think the week has been both one of encouragement and one of deep concern. I think that Congressman Levin, of Michigan, who was with me a good portion of the week, and Congressman Lowry, in the Northwest, share with me a very deep concern about the problems that confront Native American families and reservation-based families within this country and the host of social problems that confront these families, most of which find their root in severe economic conditions within the reservations.

All of the reservations that we visited this past week experience unemployment. At its best, it's somewhere between 35 and 40 percent and, at its worst, between 85 and 90 percent. In many instances, the unemployment was created by circumstances beyond the control of the Indian nations, such as a slump in timber sales, the closing of uranium mines or copper mines, the price of coal dropping. Across the board, time and again, we saw dramatic unemployment.

The symptoms and the problems that came from that unemployment are not unlike what this committee has seen in other parts of the country. The problems that we see in terms of alcohol and substance abuse, in family violence, in teenage suicide, all of those syndromes are the same ones that we have seen in the industrial cities of the North when plants have closed down, the same syndromes we now see in the farm families that are under financial strain.

What concerns us so dramatically about the Indian nations is that these populations are concentrated, and there are little or no other resources for these nations to call upon.

I was encouraged over this past week by finding what I felt was a rather sophisticated system for the delivery of services to the people and the families of the Indian nations by those tribes, sophisticated in the sense that they understood the problems, that they had developed a network to work on them. And when you consider the short period of time that the Indian nations have had to develop these social programs under the program of self-determination, it was really quite dramatic how well run they are.

The problem, obviously, is that they are so underfunded and resources are so scant that there is no way that those social service delivery systems are able to meet the demands that are being put upon them because of the economic downturns in and around so many of the reservations.

We hope this morning to be able to expand upon that record. I think already in our discussions with the cross sections of tribes and tribal leaders that we have talked to this week, we have many, many suggestions that we think will improve the relationships between the Federal Government and the Indian tribes. As we have said in each of our stops, this hearing is to be a beginning.

I also have the honor of sitting on the House Interior Committee, which deals with many of those relationships between the Indian nations and between the United States, and I look forward to lending my efforts as legislative vehicles come to that committee. And we are joined today by Congressman Bill Lehman, who, more importantly, sits on the House Appropriations Committee, which makes a lot of the things go in terms of policy, because it is the funding arm of the Congress of the United States. And I am really pleased and honored that Congressman Lehman has come out here from his district in Florida to spend time with us to hear the witnesses.

Bill, do you have any opening statement you would like to make?

Mr. LEHMAN. I think Congressman Miller has expressed it just as it is. We have, of course, our own problems with the Native Americans in Florida, the Seminoles, just as you have here, and many of the problems that you have here are the same as those of the people who live in my own congressional district. Thank you, George.

Chairman MILLER. Thank you. The first panel that we hear from will be made up of Gilbert Pena, who is the Chairman of the All Indian Pueblo Council; Toni Martorelli, who is the Director of the Governor's Office of Children and Youth; Danielle Monte, who is a member of the Drug Busters from the Southern Ute Tribe; Toni Rael, who is also a member of the Drug Busters of the Ute Tribe. They will be accompanied by Sue Velasquez. Another witness will be Philip May, who is an associate professor of sociology at the University of New Mexico; and Francisca Hernandez, who is the executive director of the Albuquerque Area Indian Health Board, who will be accompanied by Ona Lara Porter, who is the director of planning for the Albuquerque Area Indian Health Board.

If you will come forward, we will take you in the order in which I called your name. We welcome you to the committee, and we appreciate the help you have given us in setting up this hearing. Your written statements will be put in the record in their entirety. And to the extent that you can summarize, we will appreciate that, so that will leave time for questions by the members of this committee. Proceed in the manner in which you are most comfortable. We are a pretty relaxed committee, so there is no need for anyone to be nervous.

[Opening statement of Chairman George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

This morning's hearing is the last in our week-long investigation into conditions among Native American families and children. This week we visited communities and held a hearing in the Northwest, then travelled to the Navajo and Papago Reservations in Arizona. Yesterday, we heard from providers and tribal leaders during our visit to the Gila River Indian Community.

BEST COPY AVAILABLE

We are pleased to be in Albuquerque today, and look forward to receiving testimony from tribal learders, parents, young adults, and providers from reservations and Pueblos in New Mexico and Colorado.

We will conclude this afternoon with a site visit to the Laguna Pueblo. We will get a chance to visit a model program for teens, which focuses on preventing many of the problems which confront Native American families.

The record we have created already this week enlarges substantially our knowledge of children and family issues within the Native American community.

This morning will further expand that record. We will get a firsthand report on unemployment and its effect on the family, and learn about housing, sewer and electricity shortages. We will also learn about a tribally-run school which acts as a base for a comprehensive array of youth and adult services. We will see how foster care and child welfare services are working.

Once again, we will receive testimony on the link between alcohol abuse and many severe family-related problems, including Fetal Alcohol Syndrome. We will learn about a comprehensive community-based alcoholism prevention program, as well as a program which students have begun on their own to encourage other students to remain drug and alcohol free.

I am looking forward to our hearing and our site visit. Your testimony will become part of the record of Congress.

Our Committee has pledged to care about all children and families in America, to listen, to look for gaps in services, to learn from positive, successful programs. That is why we are here today, and we deeply appreciate your hospitality.

STATEMENT OF GILBERT PENA, CHAIRMAN, ALL INDIAN PUEBLO COUNCIL, ALBUQUERQUE

Mr. PENA. Thank you, Mr. Chairman. Welcome to Albuquerque and to the Indian Pueblo Cultural Center. We usually refer to this place as welcome to Pueblo country. But we have some of our Navajo neighbors here, so we'll just refer to it as Indian country.

The status of Indian families, like families within other ethnic groups, has changed considerably, given the poor economic base which exists within most Indian communities, given the severe reduction of Federal and tribal programs for Native Americans.

The changes have caused hardships and devastating conflicts within Indian families. Leaders of the Indian community are concerned that so many of their people are having increasing difficulties in dealing or coping with today's society's demands. Leaders are concerned about the negative effects of modern life has both for the individual and the Indian family structure.

The heart of the Indian community is the family. Yet there are increasing economic and social threats that could cause the disintegration of this very family structure.

Current social programs designed to aid the Indian family are wasted and inadequate and often fail to deal with the complex issues that affect the Indian communities. Child abuse and neglect and the concurrent emergence of family violence, for example, are problems which are both fairly new and devastating to the Indian communities. The newness of the issues renders the Indian families ill equipped to adequately address them. And the devastation that results from these issues seems to result in a negative spiral of family violence often witnessed within other ethnic groups.

At the core of these issues Indian leaders have found various negative factors. Unemployment and underemployment are the foremost of these negative factors. Alcoholism, ensuing from many parents' poor self-concepts, is often called a maladjusted means to cope with family stress.

BEST COPY AVAILABLE

The often nonexistent economic base within reservations are also contributing factors.

Mr. Chairman, we have some data in our testimony that we hope will be beneficial to the committee that pertains to the Albuquerque Area Office. I commend this committee for holding these hearings throughout the country, and we stand ready to assist you in any way we can. I think in your opening remarks you essentially addressed the main problem. The problem is there, but the lack of sufficient funds to address the problems is very clear.

In our Pueblo communities we do have court systems where many cases of this nature are brought about. However, the court systems are sophisticated and they are well equipped, as far as staff is concerned. However, when we have an individual who is involved in child abuse and we try to make a commitment to an institution to assist that individual in dealing with his problems, the courts and the tribes cannot adequately support that commitment, primarily because many of the institutions charge from $50 all the way to $225 a day. And obviously many of our tribes—in fact, all of our Pueblo communities cannot afford that type of a liability on their behalf.

Again, Mr. Chairman, thank you for listening to our concerns. And again, we stand ready to assist this committee. Thank you.

Chairman MILLER. Thank you.

[Prepared statement of Gilbert M. Pena follows:]

PREPARED STATEMENT OF CHAIRMAN GILBERT M. PENA, ALL INDIAN PUEBLO COUNCIL, INC., ALBUQUERQUE, NM

Good Morning, on behalf of the nineteen New Mexico Pueblos, I welcome you to the Indian Pueblo Cultural Center. I would like to thank you for this opportunity to host your hearings on Indian Children, Youth and Families.

The status of Indian families, like families within other ethnic groups, has changed considerably. Given the poor economic bases that exist within most Indian communities, and given the severe reduction of Federal entitlement programs for Native Americans, the changes have caused hardships and devastating conflicts within Indian families. Leaders of the Indian community are concerned that so many of their people are having increasing difficulties in dealing or coping with today's society's demands. Leaders are concerned about the negative affects that the complexity of modern life has for both the individual and the Indian family structure. The heart of the Indian community is the family; yet, there are increasing economic and social threats that could cause the disintegration of this family structure.

Current social programs idealized to aid the Indian family at risk, are waging an inadequate and often ill-advised battle against the complex issues that affect the Indian community. Child abuse and neglect, and the concurring emergence of family violence, for example, are problems which are both fairly new and devastating to Indian communities. The "newness" of the issues renders the Indian family ill-equipped to adequately address them, and the devastation that results from these issues seems to promote the negative spiral of family violence often witnessed within other ethnic groups.

At the core of these issues, Indian leaders have found various negative factors. Unemployment and underemployment is a foremost of these negative factors. Alcoholism, ensuing from many parents' poor self-concept, is often caused by maladaptive means to cope with family stress. The often non-existent economic base within reservations, are also contributing factors.

The number and the severity of the problems faced by the Indian family is well illustrated by data contained in an Indian Health Services' Annual Report of Social and Mental Health Services provided to Indian people from the Albuquerque Area Office, in 1981. The report reveals that IHS' Mental Health Division provided services to 11,676 Indian clients; approximately 25% of the total, local Indian population. The problems ranged from "abortion conflicts" to "urban community problems." There were a total of 84 problematic categories, and the IHS' own staff read-

BEST COPY AVAILABLE

ily admitted that they were able to service only a small percentage of Indian clients who experienced such problems. Even a peripheral review of the IHS data would reveal the complexity of the problems and would give strong evidence that the Indian family is increasingly at risk of disintegration.

Consider, for example, the number of clients who were seen because of the existence of "adult-child relation problems": In total, 634 individual cases addressed this issue alone, of which, 236 were individuals classified as children. In addition, 114 cases addressed the concept of the "broken family"; a concept virtually non-existent in Indian communities a few decades ago. Further, 105 cases of "child neglect and abuse" were also reported in the study. The question clearly arises as to the factors contributing to so many of these problems. A partial list of possible answers would include the following, also reported in the study; 1,035 clients of alcohol-related abuses; 655 cases of anxiety-related problems; 200 cases of clients reporting confusion/disorientation; 673 clients reporting severe depression; 381 cases of marital-conflict, and the list goes on indicating the severity and progression of the overall problems.

Studies such as these are only meaningful if a desire exists from service providers to rectify their findings. The need for additional resources is obvious; however, awareness of the issues, concentrated efforts, and accountability of existing programs, are also means to address the devastating and debilitating factors affecting Indian families, their children and the overall welfare of the community. I urge this committee to help us face these issues with concerted efforts, and not to treat these problems in a perfunctory manner; the need to improve the quality of life for Indian families, and the need to prevent the disentegration of what is, after all, the true wealth of the Indian community, must not be easily overlooked.

STATEMENT OF DANIELLE MONTE, DRUG BUSTER, SOUTHERN UTE TRIBE

Ms. MONTE. Hi. My name is Danielle Monte. I'm 13 years old and a member of the Southern Ute Tribe. The reason I joined the Drug Busters was because my grandfather was killed by a drunk driver.

I know how it feels to be around drinking because the whole community has problems from it. For instance, trouble with the law, trouble in school, trouble with friends and a lot of people hurt by alcohol and drugs. I would like something better for myself, and I would like to help other people from our community who are into drugs and alcohol.

[Prepared statement of Danielle Monte follows:]

PREPARED STATEMENT OF DANIELLE MONTE, MEMBER OF THE SOUTHERN UTE TRIBE, IGNACIO, CO

Hi! My name is Danielle Monte. I'm 13 years old and a member of the Southern Ute Tribe. The reason I joined the DRUG BUSTERS was because my grandfather was killed by a drunk driver. I know how it feels to be around drinking because the whole community has problems from it, for instance, trouble with the law, trouble in school, trouble with friends, and a lot of people hurt by alcohol and drugs. I would like something better for myself and I would like to help other people from our community who are into drugs and alcohol.

We've never had alternatives to do before. We live 25 miles from Durango and literally have nothing available in Ignacio. (Out side of school functions and sports) Being from a poor community doesn't help either, except being in the Drug Busters has been a good experience in working for and earning most of our funds. This gives a person a feeling of a sense of accomplishment.

STATEMENT OF TONI RAEL, DRUG BUSTER, SOUTHERN UTE TRIBE; ACCOMPANIED BY SUE VELASQUEZ, VISTA VOLUNTEER, IGNACIO, CO.

Ms. RAEL. Hi. My name is Toni Rael. I'm 15 years old and a member of the Southern Ute Tribe. A group of concerned people in our community started Drug Busters. They were concerned about

BEST COPY AVAILABLE

the alcohol and drug use and abuse in our community, especially among the young people.

Since there isn't a place for the young people to hang out, most of them just roam the streets and usually get into some type of trouble.

Just over the last couple of years, the Drug Busters has provided us with alternative activities to participate in, and they also acquired a building. This is being renovated presently and will be used as a teen center.

One of the highlights for me was the Second Annual Run Against Drugs. We ran 350 miles, relay style, to Denver to show our concern about alcohol and drug use and to show other young people that there are better things to do than alcohol or drugs. During the run I got to know many other people I didn't even know were alive and vice versa. I met people from different groups and different places that shared the same concerns that I did. It was a blast.

SOUTHERN UTE COMMUNITY ACTION PROGRAMS
ALCOHOLISM CENTER
Post Office Box 294 — Phone 563-4245
IGNACIO, COLORADO 81137

January,1986

U.S. House of Representatives
Select Committee on Children,
Youth and Families

Mr. George Miller, Chairman:

We live in a Tri-Ethnic Community. Native American, Spanish, and Anglo. Our Chemical People Task Force (Drug Busters) started in November 1983 when Nancy Regan went on national television expressing the facts of each Community doing for it's own Community in the problem areas of Alcohol and Drug Abuse. From that Community viewing some 20 youth and 10 adults deceided to do a "Big Event" and get people aware and into alternatives for Alcohol and Drug Abuse in our area. Since that time many people in different Communities are becoming aware of the problems and are showing a great interest in being part of this Annual Run.

Robert Buckskin and Abel Velasquez set up the course, figured out the miles per day, gas etc. and the week before the "Run" made the trip to designated stops and asked for help in food and/or sleeping arrangements. Funds for the "Run" were generated by donations,and many fundraisers. (dinners, bake sales, feasts, raffles, etc.) Youth had signed up ahead of time and we had practice runs two months ahead of the run to get in "shape". We carried a scrol to the Capitol telling our legislators that "We care about our community and Nation in the areas of Alcohol and Drug Abuse." It hurts so many people in so many ways.

The first year we had 40 youth and 12 adults from Ignacio relay run (350 mi.-4 days). Many of our youth had never been out of Ignacio, and the ones who had been to big cities had never been able to take advantage of various activities available while they were there.

BEST COPY AVAILABLE

We treated them to Casa Bonita, Elliches, and Celebrity Lanes that week-end. The Holy Name Catholic Church was wonderful in putting us up and feeding us to two breakfasts. Other agencies who helped along the way were Knights of Columbus, American Legion, Lions Club, Schools, Churches, etc.

Our 2nd Annual Run 1984--always the 3rd week of June--with other youth and adults from Sterling, Trinidad, Adron, and Salida, participated in the "Run". Each Community ran from their respective towns and met us in Denver, Friday June 21, at the Capitol for a ceremony. Approximately 100 youth and 40 adults attended. Because of the awareness from our Task Force, we have done several presentations to schools (youth and adult--two in New Mexico) and other prevention (alternative) activities. Among them being the Area National Indian Health Services. We seem to be getting State and National recognation for our activities. Another activity is the Teen Center and also monthly activities for our youth.

The 3rd week of June 1986, will be our 3rd Annual Run. We have been contacted by four other Communities (besides which have already been named) who would like to participate with us. We feel this is the most rewarding activity available to so many at one time. The Run being so important for the awarness of the problem of Drug and Alcohol Abuse and positive alternatives to such. The Run is also extremely rewarding in showing youth and adults that there are "lots" of people who "care", and teaches one to live and appreciate others when having to do something in a "team" effort. Some other activities we do are: all night chemical free dances, all night New Years' Eve party, monthly activities such as tubing, swimming, movies etc. which were never available before. The Teen Center will be both educational and recreational. We hope to open soon (month or two-it's taken a year to renovate) and start a Big Sister/Big Brother program and Pier Tutor program.

We are non-profit and have no regular incoming funds. We live in a poverty level area. We are supported by our Town, TRibe, and Schools, plus monthly fundraisers to keep going. Our core group at this time is 35 youth and 12 adults.

Sincerely,

Dottie Dodd

Dottie Dodd
Prevention Coodinator

BEST COPY AVAILABLE

BEST COPY AVAILABLE

This brochure is produced and distributed by the Southern Ute-Ignacio Chemical People Task Force and the Ignacio Drug Busters to publicize their activities.

Anyone wanting more information on the organization or its activities for youth groups can write to:

Ignacio Drug Busters
P.O.Box 294
Ignacio, CO 81137

Youth Officers-

President - Karla Ribera
Vice President - Teresa Foutz
Secretary - Katrina Gallero
Treasurer - Kelly Velasquez

THE GREAT STRUGGLE

In this world there is a great struggle,
People in this world abuse their bodies,

They don't realize what they are doing until it is too late.

One day a few people got tired of it and wanted to do something about it.

They gathered the youth in their community that are concerned about this abuse.

Now the youth are trying to show people all over the world that they care and want them to try and stop doing what they are doing to their bodies.

We hope that one day this great struggle will end.

by McKean Walton

Read by the author at the state capitol building, Denver, CO, "Run Against Drug Abuse," June 1985.

IGNACIO DRUG BUSTERS.....

An alcohol and drug prevention group providing awareness and education and alternative activities for the youth of the Southern Ute-Ignacio Community.

BEST COPY AVAILABLE

TEEN CENTER

This has been one of the major group projects of the past year. Once a building was found that would be suitable as a recreation center, a contract to lease the building was negotiated. Renovation work began with the addition of a new roof and renovation of the inside of the building. Once the building is completed, it's use will be governed by by-laws drawn up by our youth members. Plans are to make the center educational as well as recreational by having computers available, tutoring sessions, and a place to just talk.

THE RUN AGAINST DRUG ABUSE

The Ignacio Chemical People Task Force, in conjunction with the Southern Ute-Ignacio Community, helped sponsor the 1984 and 1985 "Run Against Drug Abuse." The run is held the third week in June with runners starting at the Colorado-New Mexico border just south of Ignacio and running a distance of 325 miles to the Capitol Building in Denver. Each time, the young runners carried a message to the Capitol---the first year the message was from the mothers of the community and the second year the youth of the community wrote the message. Both messages stated concerns about the abuse of drugs and alcohol. The message was delivered on the Capitol steps with various state, local and educational representatives in attendance.

Each year, forty young people from the area ran relay style with ten youth to a team. The group as a whole covered 80 miles a day, with each runner running two-tenths of a mile in turn. At pre-determined places along the way the runners were fed and housed by various groups, organizations and individuals.

In 1985, the runners from this area were joined by other youth task forces from across Colorado and all the groups met in Denver and ran to the Capitol together.

Together, these young people have shown their concern and caring for others by the commitment and sacrifice necessary for a project that requires so much time, effort and planning.

OTHER ACTIVITIES

MOVIE NIGHT - Transporation is provided for the youth to enjoy "Dollar Night" in Durango.

SWIM PARTY - The community pool is rented for two hours of swimming.

HOT DOG PARTY - Held after swimming with youth donating food items.

ALL NIGHT NEW YEAR'S EVE PARTY - Music, dancing, movies, snacks and games are provided from 9:00 pm New Year's Eve until 6:00 am the following morning.

BEST COPY AVAILABLE

Ignacio youths to Run Against Drugs

1995

By Joel Millman
Herald Staff Writer

IGNACIO — A group of Ignacio youths will run 325 miles later this month to persuade others not to let drugs and alcohol control their lives.

The second annual Run Against Drugs, sponsored by the Southern Ute Indian tribe and the town of Ignacio, is the brainchild of a local drug- and alcohol-counseling group called the Chemical People's Task Force.

Last year, 40 youngsters ranging in age from 5 to 18 ran relay fashion from the New Mexico state line to Denver to publicize their concern about drug and alcohol abuse in their community.

The youngsters will repeat the arduous journey this year, starting June 17 and arriving at the State Capitol June 22.

"The purpose of this is we want to develop a core of young people who care about people with drug and alcohol problems," said task force president Robert Buckskin. "The way they show their concern is by running and suffering."

Buckskin said 30 of last year's runners will be making the trip again and 10 newcomers will join them.

A few of last year's runners, however, didn't "earn the right" to go again, he said.

"You earn the right to run by how you feel the year before," he said. "If you live by dealing in drugs or using alcohol then you have no right to be on the run."

Southern Ute Vice President Doug Dodd said she sees the run as a way of showing that there is an alternative for young people to giving in to peer pressure and using drugs and alcohol.

"We're trying to show that there is a better life than getting involved in drugs and alcohol," she said. "We're saying, 'Hey, Asterios look at us. We don't need that.'"

Youths from several other communities also will be running this year and will meet the Ignacio contingent at the Capitol for a welcoming ceremony.

Dodd said Colorado Gov. Richard Lamm, his wife, Dottie, Denver Mayor Federico Pena, former Denver Bronco Randy Gradishar, Ignacio Mayor Rena Quintana and Southern Ute Tribal Chairman Chris Baker have been invited to the welcoming ceremony.

Dodd said most if not all of the youngsters going on the run either have had alcohol or drug problems or have family members who do.

Although the organizers want the participants to be persons of

HERALD/JOEL MILLMAN

KENNETH RICHARDS helps Doug Dodd stretch before running three miles last week in preparation for the 325-mile Run Against Drugs from the New Mexico state line to Denver on June 17-22.

their accomplishments, Buckskin said he tries to impress on the runners that caring comes before pride.

"I tell them they're not going on the run to be a star, to be applauded," he said. "The are doing it to show they care and you don't have to get something back to give of yourself."

STATEMENT OF TONI MARTORELLI, DIRECTOR, GOVERNOR'S OFFICE ON CHILDREN AND YOUTH, SANTA FE

Ms. MARTORELLI. I'm the other Toni on the panel. Good morning. On behalf of Governor Anaya, I welcome you to New Mexico. Thank you for letting me come and address your committee.

I am pleased to address this committee on the issue of trends in Indian families. When my staff first received notice of this hearing, we heard it as, transient Indian families. Obviously, this was a mistake. Although it seemed humorous at first, on another level it does strike at a truth of Indian families in New Mexico.

The majority of Indian families in New Mexico are living in poverty. In that sense, Indian families are similar to that now familiar Reagan-created figure of the transient drifting on the streets of an American city.

Both the transient and the Indian families are suffering from Federal social service cuts brought on by the Reagan administration. The impact on Indian children has been particularly devastating. I do not presume to speak directly for Indian children, and I am sure that other witnesses here can relate direct personal knowledge as to the impact of the Federal cuts on the lives of Indian children and youth. I would like to address several issues that the State of New Mexico perceives as major issues in the area of Indian children and youth and possible Federal, State, and tribal solutions to those issues.

The major issue in the delivery of services to Indian children and youth is simply the lack of money. The major Federal programs that serve Indians and poor people in general have been cut at the expense of the poor people of this country. One of the major Federal statutes concerning Indian children, the Indian Child Welfare Act of 1978, has never been adequately funded. And as a consequence, the responsibilities allocated to the tribes under that act are almost impossible to fulfill. Our State social workers attempt to comply with the act, but continually run into problems because the tribes do not have sufficient resources to administer their responsibilities under the act.

A typical example is in the area of abuse and neglect. Our State social workers and State courts are required to transfer certain child custody proceedings to tribal courts. And we do not object to transfering those proceedings because we support the ICWA. However, because the tribes have never been adequately funded under the ICWA, it is very difficult for the tribes to comply with the act.

As a consequence, the State sometimes retains custody of Indian children improperly simply because the tribes do not have the resources to meet their obligations under the ICWA. This is just one example of the harm caused by inadequate Federal funding of the ICWA.

The State of New Mexico has approximately 110,000 Indians or 9 percent of the State's population. Approximately 11 percent of the State's children are Indians. This Indian population is served by the Federal Government, State government, and 21 separate tribal governments.

The State of New Mexico is committed to supporting and recognizing tribal government sovereignty in the area of their internal

domestic relations. Indian children and teen youth are within the internal domestic relations of the tribes. Therefore, in the majority of cases involving an Indian child, the tribes have primary jurisdictional responsibility. Indians are members of their tribes and are entitled to services from their tribes.

However, Indians are also State citizens and are therefore entitled to all State social services on a nondiscriminatory basis. And the Federal Government, as trustee for Indians, is also obligated to provide services to the tribes.

While the Federal, State, and tribal governments may argue about which government is ultimately responsible for the costs of serving Indians, the problem still exists in the Federal, State, and tribal arrangements to deliver services to Indians, but those problems certainly are not the result of unconstitutional acts of State government or State employees in the division of services among State citizens.

One would assume that this tripartite agreement would effectively protect and provide services to the Indians of New Mexico. Unfortunately, severe gaps in the delivery of social services to Indians are present in a number of areas.

Before describing these areas, I would like to point out those areas where the State of New Mexico, the Federal Government, and the tribes have reached and effectively served Indians.

Federal means-tested programs administered by the State and the tribes are a major source of support for Indians in New Mexico. No significant issue exists, other than the low funding levels, in the administration of these programs. In specific reference to the ICWA, the Human Services Department of the State of New Mexico and the Navajo Nation have entered into a joint powers agreement for the effective implementation and administration of the jurisdictional allocation of the ICWA. The State is open to entering into similar agreements with other tribal governments of New Mexico and has already begun negotiations with several tribes.

I think you can see that we are on the road to trying to resolve some of the issues. But the major issues that must also be resolved are in the area of child abuse.

Federal jurisdictional impediments and Federal Supreme Court authority have created a void when it comes to authority to prosecute perpetrators of child sexual abuse on the reservation. In addition, the institutional arrangements for the identification of abused children, reporting requirements, investigation procedures, and treatment is not available.

Sexual abuse of Indian children on the reservation is not a major crime under Federal jurisdiction. Treatment for the perpetrator and the abused child is generally unavailable. Prosecution by the Federal Government through the U.S. attorney's office is unavailable because of the limitations of the Major Crimes Act.

Fortunately, there is an easy solution to this problem. I urge this committee to support Senate bill 1818 and House bill 596, which would amend the Major Crimes Act to include child sexual and physical abuse as a major crime. The amendment of the Major Crimes Act to include child sexual and physical abuse is simply a first step in the long road to addressing abuse problems. Simple

prosecution, without treatment to the victims of abuse and the perpetrators of abuse, does not solve the real problem. This committee should study the issue of providing treatment to the victims and perpetrators of abuse who reside on Indian reservations.

The lack of mental health treatment on the reservation relates to a second significant problem area that I would like to mention briefly. In the area of mental health generally, significant complex jurisdictional problems with United States and State constitutional implications exist in the treatment of mentally ill Indians who live on the reservation. If an Indian patient who resides on the reservation refuses voluntary hospitalization and the problems cannot be treated locally, then the central question becomes an involuntary commitment for treatment.

The facts necessary for commitment are outside the jurisdiction of a State district court. And although the tribal court has jurisdiction to hear the factual case, the United States and State constitutional problems of due process inhibits State agencies from honoring tribal court commitment orders to the State mental health hospital. The solution to this problem should be arrived at by Congress after they have had the opportunity to gather significant and specific tribal input and study the problem in greater detail and explore the legal implications.

I do not want to make a recommendation as to the solution to the above problem because of the lack of adequate study of the issue. However, I would like to emphasize this issue simply because it impacts on the mental health treatment of Indian children in New Mexico.

I thank you very much for hearing me out on this issue, and thank you very much for coming to New Mexico.

Chairman MILLER. Thank you.

[Prepared statement of Toni Martorelli follows:]

PREPARED STATEMENT OF TONI MARTORELLI, DIRECTOR OF GOVERNOR'S OFFICE ON CHILDREN AND YOUTH

Mr. Chairman, and members of the Committee on Children, Youth and Families, I am pleased to address this committee on the issue of trends in Indian families. When my staff first received notice of this hearing it was mischaracterized as "transient Indian families." Obviously this is a mistake that may be humorous; however, on another level it does strike at a truth of Indian families in New Mexico. The majority of Indian families in New Mexico are living in poverty. In that sense then, Indian families are similar to that now familiar Reagan-created figure of the "transient" drifting on the streets of any American city. Both the "transient" and Indian families are suffering from the federal social service cuts brought on by the Reagan administration. The impact on Indian children has been particularly devastating. I do not presume to speak directly for Indian children and I am sure that other witnesses present here can relate direct personal knowledge as to the impact of the federal cuts on the lives of Indian children and youth, I would like to address several issues that the State of New Mexico perceives as major issues in the area of Indian children and youth and possible federal, state and tribal solutions to those issues.

The major issue in the delivery of services to Indian children and youth is simply the lack of money. The major federal programs that serve Indians and poor people in general have been cut at the expense of the poor people of this country. One of the major federal statutes concerning Indian children, the Indian Child Welfare Act of 1978, has never been adequately funded, and as a consequence, the responsibilities allocated to the Tribes under that Act are almost impossible to fulfill. Our state social workers attempt to comply with the Act but continually run into problems because the Tribes do not have sufficient resources to administer their responsibilities under the Act. A typical example is in the area of abuse and neglect. Our

BEST COPY AVAILABLE

state social workers and state courts are required to transfer certain child custody proceedings to tribal courts and we do not object to transferring those proceedings because we support the ICWA. However, because the tribes have never been adequately funded under the ICWA, it is very difficult for the tribes to comply with the Act. As a consequence, the State sometimes retains custody of Indian children improperly simply because the tribes do not have the resources to meet their obligations under the ICWA. This is just one example of the harm caused by the inadequate federal funding of the ICWA.

The State of New Mexico has approximately 110,000 Indians or 9.% of the state population. Approximately 11% of the State's children are Indians. This Indian population is served by the federal government, state government and 21 separate tribal governments. The State of New Mexico is committed to supporting and recognizing tribal government sovereignty in the area of their internal domestic relations. Indian children and youth are within the internal domestic relations of the tribes. Therefore in the majority of cases involving an Indian child, the tribes have primary jurisdictional responsibility. Indians are members of their tribes and are entitled to services from their tribes. However, Indians are also state citizens and are therefore entitled to all state social services on a non-discriminatory basis. And the federal government, as trustee for Indians, is also obligated to provide services to the tribes. While the federal, state and tribal governments may argue about which government is ultimately responsible for the costs of servicing Indians, this state government administration has never denied services to Indians on the basis of their race or residence. Problems do exist in the federal, state and tribal arrangements to deliver services to Indians, but those problems certainly are not the result of unconstitutional acts of state government or state employees in the division of services among state citizens.

One would assume that this tripartite arrangement would effectively protect, and provide services to, the Indians of New Mexico. Unfortunately, severe gaps in the delivery of social services to Indians are present in a number of areas.

Before describing those problem areas, I would like to point out those areas where the State of New Mexico, the federal government and the tribes have reached and effectively served Indians. Federal means tested programs administered by the state and the tribes are a major source of support for Indians in New Mexico. No significant issue exists, other than the low funding level, in the administration of these programs. In specific reference to the ICWA, the Human Services Department of the State of New Mexico and the Navajo Nation have entered into a Joint Powers Agreement for the effective implementation and administration of the jurisdictional allocation of the ICWA. The State is open to entering into similar agreement with the other tribal governments of New Mexico and has already begun negotiations with several tribes. This cooperative arrangement between the state government and the tribal governments is fundamental to the protection of and service to Indian children. In a similar manner, this committee has acted in the interests of Indian children by your active support of the federal Woman, Infants and Children program (WIC). The Reagan Administration has shifted the human priorities of the federal budget to a questionable theory of economics that creates record deficits while taxes for the rich and corporations are cut. The end result will be further efforts by the Reagan Administration to balance the budget by cutting more social programs. I commend this committee's past efforts and success at saving WIC and I urge the members of the committee to resist further federal cuts to social services programs.

In specific reference to the problems of Indian children in New Mexico, I would like to mention two significant issues that I believe this committee should address by way of additional hearing or studies. Both of these issues are unique to Indian children because of the unique nature of federal Indian Law. Initially, I would like to emphasize that my comments are not in derogation of tribal sovereignty and the right of Indians to make their own laws. Because of the complex jurisdictional web among Federal, State and Tribal governments, Indians in need have been falling through the safety net of social services. For example, under the ICWA the tribes are given exclusive jurisdiction to handle child abuse and neglect cases involving Indian children who reside on the reservation. These cases cannot be filed in state court. But as I stated before the tribes have not been funded under the ICWA to effectively handle these cases.

Two significant areas in which the needs of Indian children have not been met are mental health and physical and sexual abuse. Society at large now recognizes that the physical and sexual abuse of children must be addressed. Indian communities just like non-Indian communities have mental health problems which manifest themselves in the physical and sexual abuse of children. When the sexual abuse of

BEST COPY AVAILABLE

Indian children occurs on the reservation, the institutional arrangements and legal authority is not present to deal with the abuse.

Federal jurisdictional impediments and federal supreme court authority has created a void when it comes to authority to prosecute perpetrators of child sexual abuse on the reservations. In addition, the institutional arrangement for the identification of abused children, reporting requirements, investigation procedures and treatment is not available. Sexual abuse of Indian children on the reservation is not a major crime under federal jurisdiction. If the perpetrator of the abuse is a non-Indian, then the tribes are prohibited from acting in the matter. And where the tribes can act, that is, against resident Indians, the scope of relief available to the tribes is limited by the Indian Civil Rights Act to a fine of $500.00 or six months in jail. Treatment for the perpetrator and the abused child is generally unavailable. Prosecution by the federal government through the U.S. Attorney's Office is unavailable because of the limitations of the Major Crimes Act. Fortunately, there is an easy solution to this problem. I urge this committee to support S1818 and HB 596 which would amend the Major Crimes Act to include child sexual and physical abuse as a major crime. The amendment of the Major Crimes Act to include child sexual and physical abuse is simply a first step in the long road to addressing abuse problems. Simple prosecution without treatment to the victims of abuse and the perpetrators of abuse does not solve the real problem. This committee should study the issue of providing treatment for victims and perpetrators of abuse who reside on Indian reservations. The lack of mental health treatment on the reservation relates to a second significant problem area that I would like to mention.

In the area of mental health generally, significant complex jurisdictional problems with U.S. and State constitutional implications exist in the treatment of mentally ill Indians who live on the reservation. If an Indian patient who resides on the reservation refuses voluntary hospitalization and the problems cannot be treated locally, then the central question becomes an involuntary commitment for treatment. The facts necessary for the commitment are outside the jurisdiction of a state district court and although the tribal court has jurisdiction to hear the factual case, U.S. and State constitutional problems of due process inhibit state agencies from honoring tribal court commitment orders to the state mental health hospital. This precise issue was addressed in *White* v. *Califano*, 437 F. Supp 543 (D.S.D.1977), aff'd, 581 F.2d 697 (8th Cir 1978). The solution to this problem should be arrived at by Congress after they have had the opportunity to study the problem in greater detail and to explore the legal implications.

I do not want to make a recommendation as to the solution to the above problem because of the lack of adequate study of the issue. However, I would like to emphasize this issue simply because it impacts on the mental health treatment of Indian children in New Mexico.

I would like to thank the committee for having this hearing and permitting me to make this short presentation.

STATEMENT OF PHILIP MAY, PH.D., ASSOCIATE PROFESSOR OF SOCIOLOGY, UNIVERSITY OF NEW MEXICO, ALBUQUERQUE

Dr. MAY. I'm Philip May. I'm a professor at the University of New Mexico. I have been asked to testify on two topics, Fetal Alcohol Syndrome and suicide.

Very briefly, my written statements point out that several of my colleagues, Karen Hymbaugh, Jon Aase, Carol Clericuzio, and I have worked with and studied Fetal Alcohol Syndrome among a number of southwestern tribes for a number of years. In general, the biophysiological features of Fetal Alcohol Syndrome are similar with Indians. That is, they manifest themselves with Indians the same way they do with other populations of the world. The epidemiology, however, tends to be a little bit unique with American Indians.

I am submitting in longer form an article which summarizes many of these points, and let me briefly highlight a few right here.

The epidemiological features of FAS have been studied in a number of the tribes in the Southwest. We screened as many Fetal Alcohol Syndrome suspects as we could possibly screen in Arizona,

BEST COPY AVAILABLE

New Mexico, and southern Colorado. We have found and identified, at least in our detailed studies, 115 fetal-alcohol affected children, that is, Fetal Alcohol Syndrome, and milder forms of fetal alcohol effects.

When you translate this to a rate, it comes out to tremendously variable rates from one cultural group to the next. They range from 1.3 per 1,000 births—that is, one out of every 1,000 babies born in some tribes, 1.3 is Fetal Alcohol Syndrome—to other groups which have rates as high as 10.3. And if you translate those to ratios, that is one out of every 750 for the better tribes, and for the tribes that have more severe problems, it's one out of 97 babies with Fetal Alcohol Syndrome.

The age-specific prevalence patterns are what I should probably highlight the most here. That is, from the age-specific patterns, we believe that Fetal Alcohol Syndrome is on the increase in all three of the cultural groups that we have looked at, Pueblo, Navajo and Southwestern Plains groups.

One thing that is very encouraging to us is that the problem of Fetal Alcohol Syndrome is highly circumscribed to a small number of women of childbearing age. 6.1 out of every 1,000 women of childbearing age produce all of the Fetal Alcohol Syndrome kids. So as a public health practitioner, that is an encouraging figure, because if you change six women out of every 1,000 of childbearing age, you can eliminate most of the problem.

There are a number of other things which we found which should be pointed out. Multiple Fetal Alcohol Syndrome children born to the same mother are also a pattern which we feel needs to be addressed. That is, the average woman who has one Fetal Alcohol Syndrome child in most of the tribes that we looked at will have more than one. They will have, on the average, 1.3. But the point is that this concentrated, small number of mothers produced most of the problems.

Many of these mothers who produced the Fetal Alcohol Syndrome and fetal-alcohol effect kids lead highly disruptive and chaotic lives, and generally they are isolated from mainstream tribal activities. That is, the tribes themselves, under no circumstances, will put up with many of their behaviors. And therefore, they have fallen outside or have wound up outside of the mainstream tribal social activities.

But in general, the gross social and cultural patterns which you have been finding all over the Nation contribute to the problem of Fetal Alcohol Syndrome. And again, the full detail of this is presented in the article which I am submitting in written form for you.

Now the other topic, suicide among Southwestern Indians, is something that I have been able to work with off and on for 16 years, not just in the Southwest, but in other States, South Dakota, Idaho, and Arizona.

I got involved in the first, "epidemic," which received considerable Federal attention, and that was at Fort Hall, ID, in the late sixties.

From that time on, we have been aware of a number of epidemics that did come up on particular reservations and then go away.

The problem, though, is that suicide is a suggestible behavior, and we do have epidemics on particular reservations off and on.

Now I am also presenting more detailed testimony. One of my former students, Nancy Van Winkle, who is now a Ph.D. candidate at the University of Kentucky, and I have studied 23 years of suicide death statistics among the different tribes in New Mexico. In this study, we have found a pattern. That is, there are periodic epidemics, and they cause tremendous problems for all tribes, but they are particularly devastating to small tribes.

The health care practitioners, the social welfare people and the tribal people themselves do their best to combat these waves of suicide with their youth, but in many cases we may lose 7 to 10 kids in an epidemic, and that is devastating to a small group of people. It is devastating to any group of people, but particularly devastating to small tribes.

Our findings indicated that Indian suicide is predominantly much more youthful than suicide in the United States, and that is virtually true with every tribe we have ever looked at. They are predominantly male. And the rates in virtually every age category under the age of 40 that you look at, most tribes have higher rates. That is, in most people under 40, most tribes do have higher rates. Now there is a tremendous variation, though. Navajos have a much lower rate of suicide than the Pueblos, and the Pueblos have slightly lower rates than some of the Southwestern Plains tribes. So there is tremendous variation from one tribe to the next.

Again, though, like Fetal Alcohol Syndrome, the one thing I should highlight is that we were very concerned, in looking at this 23-year period, as to whether the rate was increasing. There is oral history among the different tribes that suicide is a new phenomenon. We weren't sure, because we were also able to locate some Indian elders who said, "No, we did have suicide back in the old days."

Well, in the 23-year period that we studied, we found that in each one of the tribes, Navajo, Pueblo, and Southwestern Plains, the rate was increasing. Now the youthful suicide rate among all people in the United States is also increasing. But we found that the Indian rate started at a point two to three times higher and all through the 23-year period increased just as rapidly. So the point is that it is increasing.

But again, there are some tribes that don't have as big a problem right now. And I would hope that we could set up some kinds of programs which would keep it that way, that is, preventive measures which would keep the low tribes low and hopefully bring down the rates of the higher tribes.

So anyway, that is, in capsule form, my testimony on suicide among American Indians. And I have presented to you a paper entitled, "Native American Suicide In New Mexico, 1957-79: A Comparative Study." This paper is in press, and I think the committee will probably have to get permission from the journal Human Organization, that is going to publish it before it is published in the proceedings of this hearing. Thank you.

Chairman MILLER. Thank you very much.

[Prepared statement of Philip A. May Ph.D., follows:]

PREPARED STATEMENT OF PHILIP A. MAY, PH.D., ASSOCIATE PROFESSOR OF SOCIOLOGY, UNIVERSITY OF NEW MEXICO, ALBUQUERQUE, NM

TOPIC: FETAL ALCOHOL SYNDROME AMONG SOUTHWESTERN INDIANS

My colleagues, Karen J. Hymbaugh, Jon M. Aase, Carol Clericuzio and I have worked with and studied Fetal Alcohol Syndrome among many of the Southwestern Indian tribes for a number of years. In general, the bio-physiological features of F.A.S. are similar among Indians as with other populations studied in the world. The epidemiology, however, seems to be unique, although studies of this kind are rare in the entire world. Briefly here are our findings:

The epidemiological features of Fetal Alcohol Syndrome (FAS) were examined among American Indians in the southwestern United States. All FAS suspects were screened in specific populations of Navajo, Pueblo, and Plains culture tribes. A total of 115 alcohol-affected children were identified. The incidence of FAS was found to be highly variable from one cultural group to the next ranging from 1.3 per 1,000 births (1/749) for the Navajo to 10.3 (1/97) for the Plains. The pattern of age-specific prevalence indicates an increase over the past fifteen years. The overall rate of mothers who have produced fetal alcohol children was 6.1 per 1,000 women of child-bearing age with a range of 4 to 33 per 1,000. These maternal prevalence rates were important for the accurate prediction of public health risk because 25 percent of all mothers who had produced one affected child had also produced others. The average per mother was 1.3 alcohol-affected children. Other findings indicate that the mothers of these children led highly disruptive and chaotic lives and were frequently isolated from mainstream social activities. In general, the gross social and cultural patterns of the tribes studied can readily explain the variation in incidence of FAS. Full detail of these findings are presented in writing now in the article by Philip A. May, et.al., "The Epidemiology of FAS Among American Indians of the Southwest," Social Biology, Vol. 30, No.4 December, 1983.

I have studied and worked with suicide among various tribes of Indians in the U.S. off and on for sixteen years. From the first "epidemic" which received considerable attention from the federal government (Fort Hall, Idaho, Shoshone-Bannack Tribe) to contemporary situations, not too much has changed. Suicide is a problem of Indian youth and it varies greatly over time and from one tribe to the next.

One of my former students, Nancy Van Winkle (Ph.D. candidate in Sociology at the University of Kentucky), and I have studied 23 years of suicide death statistics among Indians of New Mexico. Here are some of our findings:

In a descriptive and epidemiological study we examined completed suicides among the Apache, Navajo and Pueblo Indians of New Mexico from 1957 through 1979. Death certificates constituted the primary source of data. A number of demographic and situational variables were examined for the cultural groups and similarities and differences were noted. Significant findings included a high male to female ratio ranging from 7.4:1 to 10.4:1; an age range of 10-39 for 75.4% to 93.4% of the completed suicides; and a high percentage of both males and females using extremely lethal methods, i.e., firearms and hanging, to commit suicide. Suicide rates for the Apache and Pueblo groups have been rising since the mid-1960s while Navajo rates have been rising since the early 1970s. The Apache had the highest suicide rate followed by the Pueblo and Navajo for the period 1957-1979. The age-adjusted rates range from 1.7 to 4.9 times the U.S. rate in recent years. Age-specific trends show an increase in youthful suicide rates similar to or greater than that of the U.S. population and also some increase for those 55 years of age and over in two of the groups. Traditional and contemporary forms of social integration and acculturation provide possible explanations for the differential rates between groups and the increasing rate of suicides in all three groups.

The complete detail of these facts is presented in the manuscript, Nancy Westlake Van Winkle and Philip A. May, "Native American Suicide in New Mexico, 1957-1979: A Comparative Study", in press, Human Organization, 1986.

STATEMENT OF FRANCISCA HERNANDEZ, EXECUTIVE DIRECTOR, ALBUQUERQUE AREA INDIAN HEALTH BOARD, ACCOMPANIED BY ONA LARA PORTER, DIRECTOR OF PLANNING, INDIAN HEALTH BOARD

Ms. HERNANDEZ. Good morning. My name is Francisca Hernandez. I'm executive director of the Albuquerque Area Indian Health Board. We were asked to testify on alcoholism and specifically

BEST COPY AVAILABLE

what we are doing in our organization to prevent alcoholism. We were also asked to testify on our otitis media project. We have put together two testimonies that we have submitted already to you. We will summarize some of the highlights of the written testimonies.

We will talk mostly about the alcoholism issue, since it is the biggest crisis that the communities we're serving are facing.

The majority of young people in the communities we represent and with which we are more familiar are in need of outside intervention in their lives from teachers, counselors or other professionals to try to live without difficulties. Intervention is also necessary from the judicial system, and the medical system, to help them figure out how to stay away from drugs, depression, alcohol, helplessness, poor performance in school and many other pathologies and symptoms they are facing. Though our work is mostly with Indian communities, I want to emphasize that my work with non-Indians reflects a similar picture.

Some of the problems they are facing are at home. Some of them are in school. Many of the problems reflect very severe depression.

Right now I feel shook up because I just came from dealing with the suicide of a 12-year-old little girl. She just killed herself, and I'm still under the stress of the situation.

Alcohol, drugs, early pregnancy, apathy, loneliness, despair inside, a feeling of not having anything to hang on to and extreme control from the outside is the plight of many Indian children and adolescents.

A major problem we have found is that the basic skills all human beings need to have in order to develop into capable individuals are lacking. Those skills include having a number of viable role models with whom they can identify and look up to and model their behavior after; intrapersonal skills—how to deal with the feelings that you have inside; interpersonal skills—how to deal with one another, how to negotiate, how to empathize, how to be responsible, accountable to one another; situational skills, and judgment skills. This is probably the number one problem we are finding across the Nation with all young people, Indian and non-Indian.

Entire families are being impacted by alcoholism and other dysfunctions. When we look at alcoholism, we're looking at only one symptom of a bigger problem. Other symptoms include early pregnancy, drug abuse, depression, poor performance, alienation, apathy, anomie, abuse and neglect, suicide, incest, school failure, mental illness, arrests, and so on. Families are unable to pass on these skills because they themselves don't have the skills. They themselves were victims and they in turn victimize their children.

A lot of families are suffering from child abuse and neglect, desertions, suicide, mental disturbances. And again, the parents themselves and entire families are caught in the same trauma that the children face and live. To achieve a better quality of life the circle must be broken.

We have identified the root causes of these problems as follows: tremendous social disorganization as a result of all the cultural interchanges and all of the fast social changes that are occurring in the world today, cultural disintegration, cultures in transition and

BEST COPY AVAILABLE

the confusion that creates, social poverty, and personal familial, communal, and cultural disintegration.

I want to emphasize social poverty, because many people think of poverty only in terms of economics and having houses and cars and clothes and other material things. There is another kind of poverty. Even those tribes and people who do have the money or the dollars available are unable to use it to develop themselves, socially and personally in a way that allows them a better quality of life. I'm not saying that they don't need money. They do need money, but the money is to be used to develop people socially, rather than just to acquire things or to take care of the pathologies after they have reached an end or a crisis stage. The material things only have significance within a personal development that brings dignity and respect and a social development that brings productivity, well-being and beauty to our lives.

Alienation from the larger society and racism, are issues many people don't even want to face much less try to deal with them. The self-destructive path that comes as a result of all these upheavals and the confusing messages they receive from their own culture and from the society at large constitute the basic issues that confuse their sense of identity, belonging and self-worth. Underdeveloped or completely lacking parental skills; interagency and intergroup rivalry; lack of appropriate role models not only in terms of parenting, but in terms of professional, social and civic behavior; low priorities for health and education are more specific conditions or problems. I want to emphasize that in reality, they are microcosms of the society at large. Their pathologies are more widespread. In some cases 100 precent of the populations are caught in them.

Lack of understanding of what is effective treatment on these dysfunctions and very poor resource allocation on the part of the agencies responsible for more effective treatment and early intervention makes the situation more difficult to deal with.

Existing efforts in many of the communities and among the people working in the field are too particularized and segmented. For instance, treatment has been geared in the past to the end-stage alcoholic or the person that has hit bottom with whatever problem or dysfunction they face, rather than identifying people in early stages or at risk. Efforts have not been concentrated with families as whole entities or have not addressed systems and institutions.

The problem gets compounded by the fact that those efforts have not had a clear idea of where they are going and without any clarification in terms of some kind of philosophical base. They have not analyzed critically means to reconsider and regroup in a different direction. If what they are doing does not work and the crisis continues to grow, why is it so? Why not look for the root causes and then figure a different direction? What do we believe? How will we pursue those beliefs so that change becomes a reality.

Many people involved in prevention and intervention do not have the qualifications to do an effective job. They are good people. They are well intentioned. They want to do their best. But very often they don't have the understanding and the knowledge that they need to do an effective job.

Schools do not see themselves as places where people are developed, but as training systems. I was talking to people at the school attended by this little girl who committed suicide. I was suggesting that something be done with the children at the school. They need to grieve and talk and clarify. But they are not equipped to do that. They have no idea about what to do. Yet half the school is in shock.

The institutions are as disoriented as the individuals. They work with blinders and with some kind of peripheral vision that does not allow them to look at the situation and the solutions from a more broadened and enlightened perspective.

We are working on a whole different approach. First we have come up with an integrated system of solutions. We look at alcoholism as only one, small part of a deeper problem people are facing. We look at the root causes, we look at the systems, we look at the institutions, the society at large. How do these people fit into society at large? How do they fit within their own communities? What positive things do they have? What strengths and skills do they have? We capitalize on the strengths, skills, resources they already have to empower them and assist them in finding the way out of the maze, to trace some path out of the confusion and look for system-based solutions to the problem. Alcoholism becomes only one of the things that we need to address.

In a system solution approach, all institutions in the community, have to be dealt with. The existing structures have to be reconsidered and reorganized to serve the needs of the people. Do they really serve those needs? If they don't, what can be done? The basis of any society is to serve the needs of the people. If those institutions are really not helping us, then what can we do to make them more responsive and more effective?

A plan to attack the root causes of the problem is strategized. We begin by working with the councils. Our work with the councils is aimed at educating them on the problems, their causes and the approaches that they could take. We do not go any further until that leadership is ready to move, because without the leadership's support nothing will work. If they decide not to buy into the plan, whatever efforts are put together, especially when we are talking about impacting systems and institutions, is meaningless. By helping them modify their perception of the problem we help them modify their own behavior and take the lead for change.

Next we assist the councils in selecting a task force of powerful individuals in the communities that represent all sectors. We train and guide those task forces in understanding the problem, planning and implementing system based solutions. Though we use the phrase task forces communities might call it Planning Committee or Interagency Council or DREAM Committee.

The task forces are made up of the various sectors of the community: the economic enterprises, the schools, the Government, the judicial system, the population at large, social services, the police, the council, religious leaders. Our training essentially creates an awareness at a critical consciousness level, not just at the gut level, or what we read in the paper or what we hear, but a critical and analytical way of looking at this problem. What is the problem?

Why is it there? What causes it, and how are we going to work ourselves out of it?

Chairman MILLER. Ms. Hernandez, could you please summarize, so that there will be time for questions?

Ms. HERNANDEZ. Yes. We work with the task forces from the different tribes according to the value system and they depart from a philosophical base with our analysis of the problem and we help them develop a philosophical base. Five, 10 or 15-year plans are made. We implement the plans one at a time and we start with the simplest ones because they need to have small successes and build themselves up to regenerate trust and confidence in their ability to succeed.

To give you an example, in some of the schools we have conducted teacher training, to incorporate the seven basic skills into the entire curriculum. We need to learn how to solve problems, whether it's math, science, walking down the street, taking drugs or making a decision about what we're going to do with our lives. Advocacy networks, networking systems, academic readiness for preschool children, parent education and adult literacy are examples of specific programs. Adult literacy is very important not just for the functional ability to recognize words and sentences, but social literacy, that allows for the understanding of their system, how it will impact them and how can they make it work on their behalf. All of the efforts are geared at making the wellness of the community the center of all activity. Right now the center of all efforts is economic development. But without social and personal development, true economic progress cannot be achieved.

[Prepared statement of Francisca Hernandez and Ona Lara Porter, director, Planning and Community Development, follows:]

PREPARED STATEMENT OF FRANCISCA HERNANDEZ, EXECUTIVE DIRECTOR, AND ONA LARA PORTER, DIRECTOR, PLANNING AND COMMUNITY DEVELOPMENT

On behalf of the membership of the Albuquerque Area Indian Health Board, I wish to express my appreciation to the committee for this opportunity to present our perspective regarding the status of children, youth and families in the Indian communities and more specifically the provisions for alcoholism prevention.

Although alcoholism and other substance abuse is recognized as the number one health and social problem among Indian people, most of the effort to address the problem has gone to treatment of those who have become seriously ill. Many programs have called themselves preventive efforts when in reality no organized strategy has been considered or put into effect that addresses the need to change the circumstances of people. Many prevention programs have limited their activities to providing information, which has proven to increase the usage rather than diminish or prevent it; or they have chosen recreation which only distracts the young people for a short period of time without any self directed change. No efforts have been made to address the problems and needs of the children, youth and the families trapped in the cycle of alcoholism.

In both Indian and non-Indian communities, our involvement with young people over the last ten (10) years has confirmed the outcomes of National research which has found the vulnerability to addictions by young people related to the following:

- The majority of today's youth are in need of outside professional intervention in their lives to try to live without getting into serious difficulties, whether in school or home, with alcohol, suicide, depression, early pregnancy or delinquent behavior.

- The basic problem the youth are confronting is that they have not learned enough skills for living as capable individuals or so they could function at successful

BEST COPY AVAILABLE

levels at school, home, in the community, at work or in society in general.

- Families impacted by alcoholism or any kind of addiction are unable to give children these skills. The children are learning not only to drink but they are learning alcoholic behavior as well. They take this behavior into all facets of their lives in school, in their interpersonal relations and later at work, into their own families and into the society at large.

- Schools do not see themselves as responsible for doing anything for children except teaching academic subjects and skills. This narrow understanding by educators is contributing to the huge rates of placements in special education, truancy, dropout and failure rates. Even children who make it through school are unprepared to get jobs, go on to other educational opportunities, or behave and accept the responsibilities of adult life.

- Alcoholism, family violence, child abuse and neglect, divorce, desertion, suicide are reaching disastrous proportions among families also. Thus, many parents do not have the capabilities to know how to give guidance to their children or how to give them those skills that will help them throughout life or even to cope with immediate behavioral problems.

The reality is that we have the means within families and schools to prepare our children in much better ways than we are presently doing. But we need to make the plan for it and then follow the plan. We need to understand that children are born dependent, but with the potential to become interdependent. In order for that potential to be developed, their bodies, their souls and their minds need to grow. But that is not an act of magic. This growth requires experiences

BEST COPY AVAILABLE

provided at home and in school and in society at large which will help them learn the skills for interdependent living.

When we see alcoholism as a prominent factor in family violence, suicide, abuse and neglect, we know that these children cannot have the experiences necessary for healthy growth. Though alcoholism is the most apparent problem, there are also the other problems mentioned above and all of them must be addressed simultaneously because one will lead to the other sooner or later. For example, the child facing a violent situation at home and failing in school is likely to attempt to commit suicide, get drunk, be full of anger, express themselves through delinquent behavior, etc. The Indian people both individually and collectively have identified the destructive effect of the use of alcohol and the development of alcoholism. This has an adverse effect upon their health, their cultural integration, their social and economic development and their psychological well-being.

The Federal government has a special legal relationship with Indian people and has consistently, through Congressional appropriations, acknowledged a responsibility for the health of Native Americans. There is a comprehensive health delivery system in place, administrated by Indian Health Service. However, despite the fact that they (Indian Health Service) recognize the seriousness of the problem everywhere in the nation, they are not giving it the attention it requires. They have treatment and prevention programs in place but neither of them have been effective in arresting the situation. The problem has grown like a cancer and has taken over the communities turning them into alcoholic communities.

Why have prevention programs not worked?

- Our society in general and communities and programs in specific have concentrated their efforts on sending

BEST COPY AVAILABLE

alcoholic people to treatment after they are approaching end stages of the disease. This is the exclusively medical or curative model.

- Efforts have been concentrated on the alcoholic and not on treating the entire family affected by the problem or dealing with the community or societal issues that have given rise to the problem.

- The people involved in prevention programs either do not have the professional qualifications to effectively do the job or do not understand the problem at a fundamental level and therefore, do not know how to make the plan to attack it.

- For many people there is the belief that all children will experiment with alcohol and that many of these will become regular users by the time they are in the seventh or eighth grade.

- The schools see themselves as places to teach isolated skills in academics, when in reality you cannot teach someone when separating his/her personal growth from the academics. This practice in our schools is a tacit admission that what happens in the classroom is naive, impractical, indifferent to the facts of life and not so useful as "wordly" experience. The classrooms of our society are not the place where rigorous and able minds are formed and where sensitive caring persons are developed. They do not provide a humanizing experience for children.

- There is a need to change attitudes toward prevention. Right now the perceptions are that if we keep the children occupied, they won't get into trouble. Therefore, recreation is emphasized without developing any skills that

BEST COPY AVAILABLE

would help them become more responsible and accountable and everything is offered already digested thus preventing critical thinking minds from developing. Adults are so insecure themselves that they fluctuate from permissiveness to punishment with very little space for young people to develop the skills necessary to deal with situations, exercise judgment, and to feel that they are true contributors to the world in which they live. The society as a whole is in a constant fluctuation of values and attitudes toward discipline and punishment and toward what is acceptable and responsible behavior.

In our approach to the prevention of alcoholism in specific and addictions and other social pathologies in general, we look at the entire socio-economic and political structure of the community and how it fits into the larger society. Then we plan our attack in an interconnected and multiphasetic fashion, recognizing that we need different strategies to meet different needs and different target populations. We work together with all community systems and people to bring health, strength and productivity to the entire community. We call this the three-pronged approach which for the purpose of clarity we separate into Primary Prevention, Early Identification and Intervention and Treatment.

Our primary prevention approach includes children, parents, families, schools, teachers, youth organizations, tribal leadership and community planning for economic or social purposes. This is a wellness model. (See Charts No. 1, 2 and 4.)

The Early Identification and Intervention aspect includes legal offenders, DWI offenders, students who have any kind of problem, workers with problems related to addictions which interfere with their work performance, patients, doctors, employers, teachers, counselors, school principals and the judicial system. The people in this category are individuals

BEST COPY AVAILABLE

61-183 O - 86 - 2

who are becoming sick and those around them who are their support network.

In the treatment category we have people who are very sick. They are either alcoholics or have serious alcohol problems.

Thus, our primary prevention is a wellness-oriented effort while the other two prongs are crisis-oriented. They all have to be addressed simultaneously because it is useless to work with a child that we are sending back to an alcoholic parent or to a racist teacher. (See Charts No. 1, 2 and 4.)

Our model is an effort to redirect our present system of having economic power at the center of all of our activities to one where the wellness of people and the community is the center and the criteria by which all decisions are made.

Since we base our society in the economic structure, all other institutions must adapt to the economic changes. This includes the religious institutions. Here is where the emotional and spiritual justifications for new accommodations must be made. Here also, is where our code of ethics is reinforced. Schools must also adapt because they are the training center for new producers and consumers. The family also must accommodate itself because they pass on the values of the society, the rules and roles of the systems, the reinforcement of the ethical perspectives and the legitimization of the legal structures. And our leadership follows the economic trends and mandates accommodating itself to the responses received from the market places. (See Chart No. 4.)

All of these structures and institutions with their values and perspectives dictate our behavior as individuals and as a community or society.

BEST COPY AVAILABLE

When we change that around and put wellness at the center of all activity, our choices and decisions change dramatically. When the family values emphasize physical and emotional health, disciplined and critically thinking minds, and responsible and accountable citizens the picture begins to change. When the health system looks at our problems in a wholistic and epidemiological fashion; when we treat the person as a total system and offer services in an interconnected manner, people begin to be in control of their own well-being. When our churches begin to develop an approach to the clarification of values that affirms the life and dignity of all people; when they offer a place for reflection and dialogue, a place for clarity, affirmation, permanence and stability, communication and peace, people will begin to feel more powerful, less alien and less anomic. When our leadership begins to fill the role of behavioral model and reflects principles of life affirmation, peace, justice and humaness, people will begin to follow their steps and to lead healthier lives for themselves. Only then will we have true justice and socio-economic development for all people.

The specific way in which we presently plan our work in the Indian communities we represent is by putting at the center the tribal needs and priorities as identified by our team and the community people. Our first target is the tribal leadership. They must understand and support the concepts and approach. They must select a group of strong, capable individuals representing all sectors of the community to form a task force. For a period of time this group is trained to understand the socio-economic conditions of all people with special emphasis on children, the epidemiological picture of the communities and of alcoholism specifically and to understand their role as change agents. We work toward making values clarification statements that include what will be promoted and what they will be looking for in the next five, ten and twenty years and plan to achieve. We help them conceive

BEST COPY AVAILABLE

what the ideal is, recognize clearly what the reality around them is and through dialogue help them identify the root causes of the problems and how to search for alternative system/change solutions. (See Charts No. 5, 6 and 7.)

We follow this with a planning period where problems, goals, strategies and detailed implementation plans are outlined. These are then presented and discussed with the tribal leadership for approval and support. And we begin the implementation activity.

Three of the communities we work with have adopted a task force approach. The first community to do so was trained over a year ago. In that community, we have planned for the following:

1. Reorganization of the entire administrative system of the community.

2. Restructure of the community's political system where a balance between traditional and modern structures was achieved bringing together all groups.

3. The establishment of a judicial system that incorporates the laws of the United States and the traditional values of the communities in a way that serves the specific needs of the people.

4. The reorganization of their school including curriculum, teachers and so on.

5. A comprehensive alcoholism prevention strategy that addresses:

   - Developing capable parents;
     Teacher training in the incorporation of human development skills into the academic curriculum;

BEST COPY AVAILABLE

- Academic readiness for children;
- A center for youth activities that includes democratic problem solving experiences for children 6-14, assistance for homework, group and individual counseling, and a recreational summer program where children under the direction of adults plan, raise the money for and manage during the year;
- An advocacy network for elementary school children and a mentoring system for youngsters in the middle and high schools;
- An adult literacy plan which is intended to raise the functional skills of all community members to a sixth grade level.

6. We have created an economic development plan which is intended to develop skills and jobs in the community which are in harmony with the land and the people which meet their fundamental needs. The plan will not promote dependency, threaten water, air or land quality or undermine their strength as a race or culture.

7. We have also planned to reorient the alcoholism treatment toward early identification and intervention where a network of the community physician, employers, religious leaders, community leadership and family will all come together to insure the sick person goes to treatment and follows after care assistance to complete recovery. There is no way that that person can remain in the community without help. A family therapy model has been incorporated into the strategy to assist the rest of the family in its recovery from the traumas suffered as a result of living with a dysfunctional person. For the end stage alcoholics, we have identified resources that can offer humane care and which frees the family from any further trauma.

BEST COPY AVAILABLE

The other two communities recently initiated their task forces with one trained in June of this year and the other in November. In the former community, they have implemented an Employee Assistance Program to aid with early identification and referral of troubled employees. The task force has also taken on a watchdog role in the community and has successfully challenged liquor industry sponsorship and sale of beer at some family events in the community- a significant change in community mores. They have also made a beginning on both short-range and long-range comprehensive plans.

The third community also has adopted an EAP for their tribal employees with the aid of our program, and is in the process of hiring an EAP coordinator. They have had an Interagency Council of service providers which has been functioning for three years also inspired by our suggestions. This group expanded to become their newly-trained alcoholism prevention task force. Though only in their infancy as a task force, their history of working together has allowed them to move forcefully through some of the early stages of planning. We attach a copy of their philosophy statement...

The Towaoc Alcoholism Prevention Task Force has been busy working on the following belief statement:

We believe about the disease:

1. That alcoholism is a noncurable but treatable disease;
2. That alcoholism is preventable;
3. That there are many people genetically predisposed to alcoholism;
4. That it impacts the entire family and the community.

BEST COPY AVAILABLE

We believe about it's roots:

1. That alcoholism and other problems such as suicide, unemployment, criminality, physical abuse and neglect are related;
2. That at the root of these problems is a lack of development of adequate self-esteem, ego strength, coping skills and other interpersonal skills.

We believe that:

1. Wellness is a new approach to alcohol problems;
2. Wellness is an individual responsibility and people can be helped to accept responsibility for their own action;
3. That the tribal government and the community people have responsibility in promoting wellness. Improved communication is essential;
4. Wellness includes social, economic, spiritual, environmental, cultural aspects and not only physical;
5. Wellness is a possibility for individuals and families in Towaoc and they are the tribe's greatest resource. Any efforts to help people reach their full potential will produce big dividends;
6. Energy for change is sometimes present and needs to be nurtured;
7. As the wellness level of the community rises, dependency on alcohol and other substances or on anything will decrease;
   People who have problems can be helped toward wellness through intervention;
   Wellness is primarily promoted by prevention and not only by treating problems after the fact.

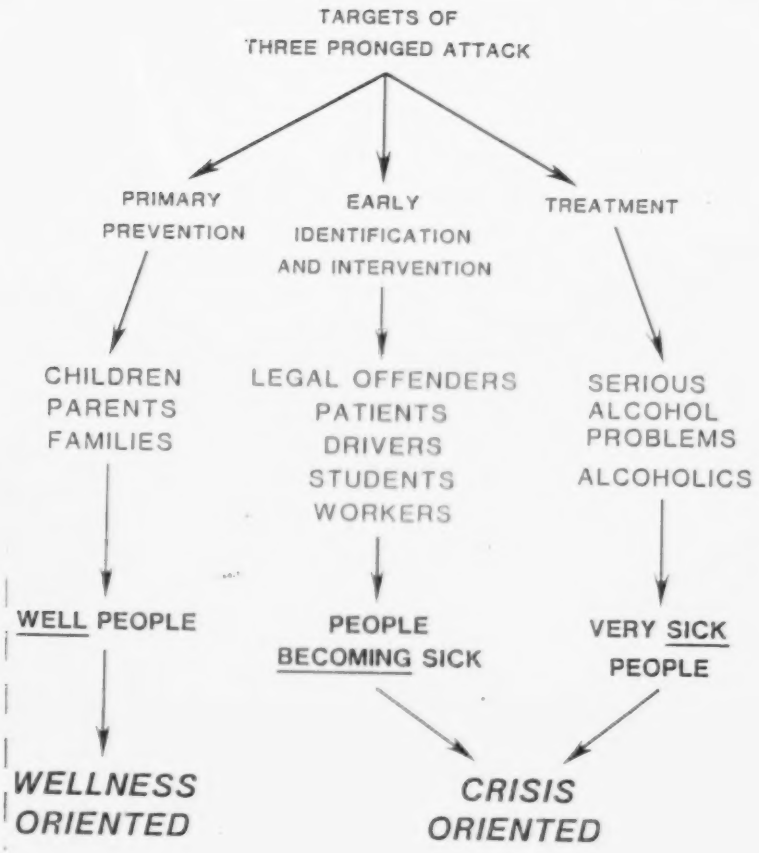
The problems affecting children and families in our society are numerous. Addictions take many forms: alcoholism is

BEST COPY AVAILABLE

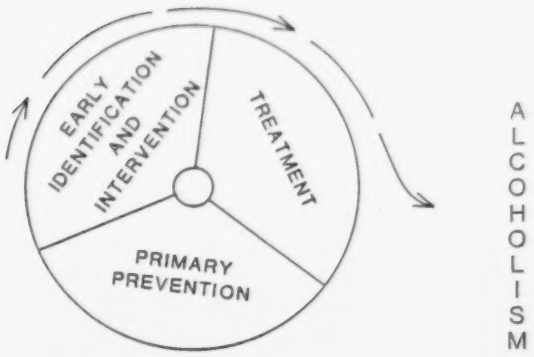
only one. Until we find the common denominator of all these problems and go after it, we will be fooling ourselves with paliatives. Because all of these problems are interconnected, we need to have solutions that are also interconnected. Because it is an issue of mental, physical, and social health we must make the wellness of the people our primary goal.

Because these pathologies include not only addictions, but sex related crimes, personal and social dysfunctions, physical, mental and sexual abuse of one another we are talking about a tremendously high number of people. Dollars alone will not improve the situation. We must have the courage to go after systemic changes. As long as economics sits in the center of all our efforts making the acquisition of dollars our main and only goal, we won't get people well. We must have the dollars as a means, but the goal must be the well-being of people.

BEST COPY AVAILABLE

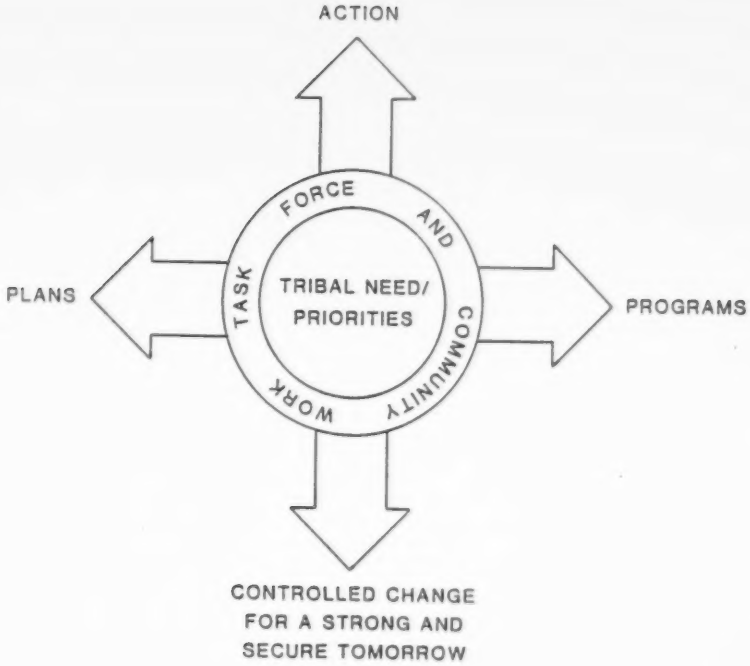

TARGETS OF
THREE PRONGED ATTACK
PRIMARY
PREVENTION
EARLY
IDENTIFICATION
AND INTERVENTION
TREATMENT
CHILDREN
PARENTS
FAMILIES
LEGAL OFFENDERS
PATIENTS
DRIVERS
STUDENTS
WORKERS
SERIOUS
ALCOHOL
PROBLEMS
ALCOHOLICS
WELL PEOPLE
PEOPLE
BECOMING SICK
VERY SICK
PEOPLE
WELLNESS
ORIENTED
CRISIS
ORIENTED

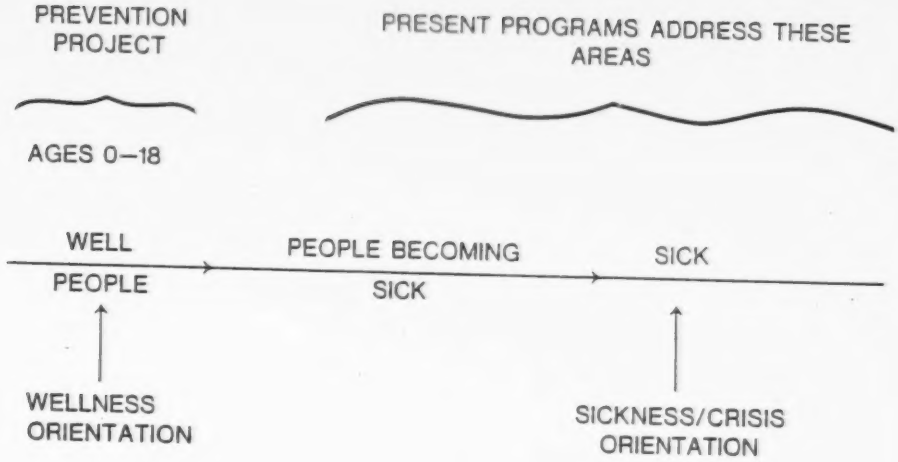
THREE PRONGED ATTACK



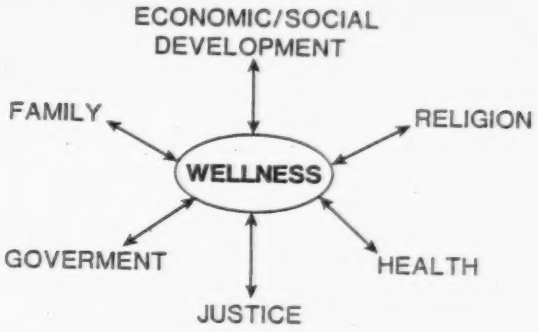
ATTACK:

- IS INTERCONNECTED AND MULTIFACETED
- HAS DIFFERENT APPROACHES TO MEET DIFFERENT NEEDS/DIFFERENT TARGET POPULATIONS
- WORKS TOGETHER WITH ALL SYSTEMS AND PEOPLE TO BRING HEALTH, STRENGTH AND PRODUCTIVITY TO THE COMMUNITY

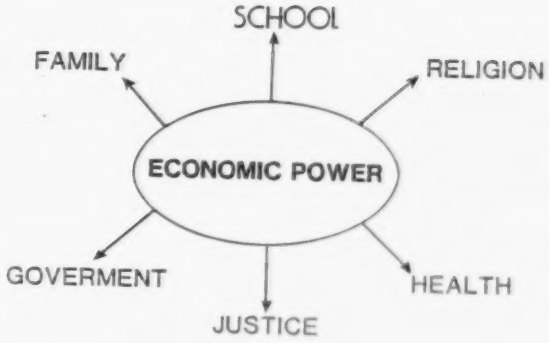

ACTION
PLANS
PROGRAMS
TASK FORCE AND COMMUNITY WORK
TRIBAL NEED/ PRIORITIES
CONTROLLED CHANGE FOR A STRONG AND SECURE TOMORROW


PREVENTION PROJECT
PRESENT PROGRAMS ADDRESS THESE AREAS
AGES 0–18
WELL PEOPLE
PEOPLE BECOMING SICK
SICK
WELLNESS ORIENTATION
SICKNESS/CRISIS ORIENTATION

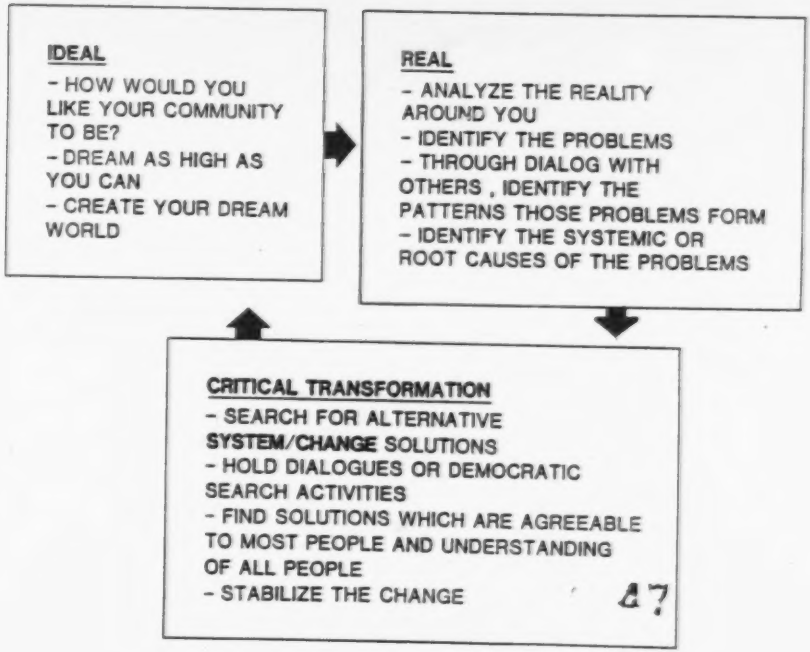
● **PROPOSED SYSTEM**



▲ **CURRENT SYSTEMS**



DEFINING AND ACHIEVING THE IDEAL


IDEAL
- HOW WOULD YOU LIKE YOUR COMMUNITY TO BE?
- DREAM AS HIGH AS YOU CAN
- CREATE YOUR DREAM WORLD
REAL
- ANALYZE THE REALITY AROUND YOU
- IDENTIFY THE PROBLEMS
- THROUGH DIALOG WITH OTHERS , IDENTIFY THE PATTERNS THOSE PROBLEMS FORM
- IDENTIFY THE SYSTEMIC OR ROOT CAUSES OF THE PROBLEMS
CRITICAL TRANSFORMATION
- SEARCH FOR ALTERNATIVE SYSTEM/CHANGE SOLUTIONS
- HOLD DIALOGUES OR DEMOCRATIC SEARCH ACTIVITIES
- FIND SOLUTIONS WHICH ARE AGREEABLE TO MOST PEOPLE AND UNDERSTANDING OF ALL PEOPLE
- STABILIZE THE CHANGE

THE IDEAL VS. THE REAL

← IDEAL →

- DIGNITY AND STRENGTH
- KNOWLEDGE AND WELLNESS
- MEANINGFUL WORK FOR ALL PEOPLE
- PRODUCTIVITY AND SELF RESPECT

← REAL →

- ALCOHOLISM & CHEMICAL ABUSE / DEPENDENCY
- CRIME AND DELINQUENCY
- VIOLENCE AND PERSONAL ABUSE & NEGLECT
- PHYSICAL AND MENTAL DISORIENTATION
- ABUSE AND NEGLECT OF OTHERS
- LOW EDUCATIONAL ACHIEVEMENT
- LACK OF PERSONAL AND SOCIAL PERFORMANCE AND PRODUCTIVITY
- LOW SELF-ESTEEM
- CULTURAL DISINTEGRATION
- OPPRESSION AND POWERLESSNESS

ADDITIONAL STATEMENT OF FRANCISCA HERNANDEZ, EXECUTIVE DIRECTOR AND ONA LARA PORTER, DIRECTOR, PLANNING AND COMMUNITY DEVELOPMENT

We represent the Albuquerque Area Indian Health Board, Inc., and are here to testify on behalf of the organization and the tribes and communities represented therein: the Jicarilla Apache Tribe, Mescalero Apache Tribe, Alamo Navajo Chapter, Canoncito Band of Navajos, Ramah Navajo Community Chapter, Southern Ute Tribe, Ute Mountain Ute Tribe, and off reservation populations within the Denver and Albuquerque metropolitan areas. We appreciate the opportunity to present our program and our concerns to the Committee.

There is possibly no other disease that is as well known in name as Otitis Media. The majority of the parents we see have at least heard the term. However, their knowledge of the disease is varied. Many parents we have interviewed have gained their knowledge of this disorder from bits of information gleened from pamphlets, brief comments from physicians or from other parents. In combining all these bits and pieces it appears that each parent brings a new and totally unique description of the problem. We have heard, explanations of the causes ranging from the lunar cycle to the birth month of the child. The father blames the mother's family or the mother blames the father's family. The remedies are just as varied and include such things as a firmly packed cotton in the ear canal, mixtures of herb tea poured into the ear canal, or simply taking the medical advice given by the local clinic practitioner. It is not surprising that this misunderstanding of the disease should occur. The medical community is just as unclear in its approach to the treatment of the disorder. The varied cures have included the removal of tonsils/adenoids, repeated piercing of the ear drum, decongestant antihistamine therapy, and many other "cures" that often failed to bring about a lasting remission of the disease. It can be easily understood why parents question the medical advice and fail to comply with treatment.

BEST COPY AVAILABLE

A detailed description of the etiology and sequelae of Otitis Media is given in most medical textbooks, and has been described at great length by medical staff. With its reference to the anatomy and physiology of the ear it is not easily understood or described without some knowledge of medical terminology. Simply stated, Otitis Media is a disease that affects the part of the ear that helps one hear. It is actually two problems. One, it is an infectious disease. It is the result of contracting a bacterial infection, much like the flu, and can be transmitted to others like any other infectious disease. The infection is easily understood and can be diagnosed and treated with antibiotics. It is also a physiological dysfunction, a part of the body (the eustacian tube), is not working like it should. Since the eustacian tube is linked to the ear, its dysfunction often results in a hearing impairment. This type of physiological dysfunction is thought to be the result of an infectious disease. This may be the case but it is of little importance since the dysfunction may persist long after the infection is successfully treated. This results in a patient who shows little or no signs of illness other than a sensation of water in their ear canals and possibly a mild hearing loss. In adults, this condition may lead to more serious complications if left untreated over a great length of time, but more commonly it results in a mild, temporary discomfort.

In children, a mild hearing loss of gradual onset is unnoticed by the child and by others around him/her. If he/she is younger than two years of age it is doubtful that he/she could verbally complain of the condition even if he/she was aware of it. This presents the obvious problem of a child with an unidentified hearing handicap during a time described as the critical period for language development.

Otitis Media has been described as the leading cause of out-patient visits in the pediatric population. Our program

50 BEST COPY AVAILABLE

has compiled statistics over the past three years. Table I. reveals the average incidence of middle ear disorders in the Native American population over a three year period of time.

Our statistics indicate a high incidence of the disorder, especially in the 0 to 3 year age level. The incidence of middle ear disease does not drop off until school age, and it appears that throughout school the disorder is present to some degree.

TABLE I.

1981-84 Percent Failing Impedance Test By Grade Level

	G R A P H I C	PERCENT	TOTAL
0-3 Yrs.	**********	30	1,221
3-4 Yrs.	**********	23	694
4-5 Yrs.	**********		1,136
Kinder	**********		1,076
First	**********		1,226
Second	**********		799
Third	**********		939
Fourth	**********		796
Fifth	**********		792
Sixth	**********		698
Seventh	**********		679
Eighth	**********		650
Ninth	**********		650
Tenth	**********		691
Eleventh	**********		507
Twelvth	**********		424
Average	**********		12,278

The other question raised is how does this relate to actual hearing loss in children. Although there is not a one to one correspondence of hearing loss to middle ear disorder, the correlation is high. If this were a disease of the pulmonary arteries affecting the function of the heart, it is doubtful that there would be any question that a life threatening condition existed regardless of the degree it hindered actual pulmonary function. The question of Otitis

BEST COPY AVAILABLE

Media and hearing loss is a question of degree. The point at which humans barely perceive the presence of sound is variable from one individual to another. Hearing is tested at a level considered as the average threshold that one perceives sound. In fact one may perceive sound at a level above or below that average threshold, therefore, a hearing loss may not be measureable for one with more than average hearing sensitivity. The sensation of sound (which is what is more typically tested) is not the same as that of the perception (comprehension discrimination) of sound. Individuals possess varying degrees of ability to discriminate and comprehend speech. A mild hearing impairment may be more handicapping to some than to others.

Table II. reveals the incidence of hearing impairment in the same population described in Table I. The hearing losses described range from borderline to severe impairment and include those hearing losses that may not be associated with middle ear impairment. The population from 0 to three years of age is difficult to test, therefore, many of the children indicated in Table I. are not included in Table II.

TABLE II.
1981-84 Percent Failing Pure Tone By Grade Level

	G R A P H I C	PERCENT	TOTAL
0-3 Yrs.	**********	12	262
3-4 Yrs.	********	8	546
4-5 Yrs.	******	6	934
Kinder	******	6	1,105
First	*****	5	1,222
Second	********	8	780
Third	*******	7	918
Fourth	*****	6	779
Fifth	*********	9	774
Sixth	*********	9	680
Seventh	**********	10	672
Eighth	********	8	631
Ninth	******	6	622

BEST COPY AVAILABLE

TABLE II. Continued

	GRAPHIC	PERCENT	TOTAL
Tenth	********	8	687
Eleventh	*******	7	485
Twelveth	**********	11	403
Average	********	8	11,500

Complications that may arise from Otitis Media as an infectious disease are fairly well controlled with antibiotic therapy. The hearing loss that may accompany the disorder is more difficult to treat. It is difficult to identify mild hearing losses in infants. When the hearing loss is identified and attributed to residual effects of the infectious disorder there is a tendency to wait to see if the body will correct itself of the middle ear problem. This "wait and see" treatment presents problems when the waiting occurs over a great span of time. For adults, a three to six month period of time is relatively short. To school age children this represents one half to three fourths of a school year. To infants in their language development period this could represent a period of time when they were to acquire 75% of the grammatic rules of their native language. Compare an eighteen month old child who converses in single words to a two and a half year old that seems to talk throughout their entire waking period. There is an incredible amount of language learning taking place in a relatively short period of time. It is unfortunate that this disorder is prevalent in infants rather than adults. If an adult medical student were prone to a disorder that handicapped learning primarily during the first three years of medical school it is doubtful that the "wait and see" treatment paradigm would be as prevalent.

Otitis Media is highly prevalent. The hearing loss associated with the disease is difficult to diagnose in the "At Risk"

BEST COPY AVAILABLE

population. It is difficult to treat the physiological malfunction, and to compound the problem in the Native American population is the fact that it is prevalent in a population that suffers from a myriad of medical, social, and economic ills. It is not beyond comprehension to see that a single, unemployed, mother of four children is not concerned with a disease that is not evident in symptoms associated with illness or severe pain. The concerns of many of these parents are life and death concerns. Moreover, there comes a point where people become disensitised to events that affect their lives or the lives of their family. One more problem in the lives of people faced with poverty, bureaucracy and unemployment becomes almost expected. What is often perceived as apathy is really an adaptive response to repeated pain. This adaptation takes place in the patient and often occurs in the health provider, too. The staff at the local clinics live with their patients in the same communities they serve and know personally the extreme hardships they endure. Thus, it becomes difficult to arouse concern over an illness that may affect a child's learning when the medical staff knows the social reality and must deal daily with cases of child abuse, neglect, alcoholism and trauma from accidents and violence.

Our project is in its fourth year of operation under the Albuquerque Area Indian Health Board, Inc. It employs three full-time and four part-time employees. The communities served are scattered throughout New Mexico, Southern Colorado, and Southeastern Utah. Four of the seven staff members provide direct service on a monthly basis to each of seven communities. Services are also available at the facility in Albuquerque. They consist of speech-language screening, diagnosis, and consultation/training services; audiological screening, evaluation, and hearing aid fitting services. As indicated by the incidence statistics in Tables I. and

BEST COPY AVAILABLE

II., our program provides comprehensive audiological screening from infancy through high school. Patients identified as hearing impaired or suffering from middle ear disorder are immediately referred for medical examination. Recommendations for medical treatment are carried out by the local physician. Anyone referred for medical treatment due to a middle ear disorder is scheduled for monthly re-examination until the test results return to normal. Our program conducts monthly audiological clinics within each health facility in order to maintain a working relationship with the local medical staff. We are available to assist in the diagnosis of middle ear disorder and to provide information related to the communicative skills of children diagnosed with chronic middle ear problems. We have begun to maintain a computerized data base of all children screened in order to more accurately monitor those in need of follow-up.

The identification component of this project is very accurate at discovering children with middle ear problems. The project has been in existence for some time and coordinates its efforts with local health resources very well. The computerized data base is in its first year of operation. It has helped us become more organized and systematic at tracking children and in conducting the screening services. However, some improvement is needed in data entry techniques and expanding the information entered on each individual child screened.

Although identification services are important, follow-up is essential to effect improvement in the conditions described by the identification component. Some follow-up services that may be either expanded or initiated include:

1. Infant Stimulation Program for chronic children:

   The "wait and see" treatment for children suffering from middle ear effusion seems to be very prevalent

BEST COPY AVAILABLE

at this point. The difficulties with this treatment measure were described earlier. In order to minimize the risks at waiting for a child to recover from an illness while under a possible hearing handicap a program of increased language stimulation for that child should be initiated. The stimulation program may provide direct speech-language therapy, possibly amplification (hearing aid), parent support/education as well as acting as the vehicle for assured medical compliance and periodic measurement of progress toward resolution of the middle ear dysfunction.

2. Surveillance Program:

A tracking/surveillance program that describes successful treatment measures and successful parent education methods, would be helpful in improving the treatment course for children with middle ear disorders. It would help standardize an approach so that children are not placed on the "wait and see" treatment schedule indefinitely. This program may also assist in parent education about the disease, and expected treatment outcomes, the importance of meeting the planned treatment schedule, and the importance of treatment compliance.

56 BEST COPY AVAILABLE

Chairman MILLER. To follow up on your testimony, what has been the result of the efforts you have made, in terms of starting in a community and getting acceptance? Do you see any perceptive change? It's clear that everywhere the committee has been, when you ask what the No. 1 health problem is, alcoholism is the response of almost everybody. I just wonder if you would agree. Do you think you might have some suggestions there?

Ms. PORTER. We have been working on the problem for nearly 5 years. It took almost 3 years to get funding because there is little to no money available for preventive programs.

Chairman MILLER. That money came from where?

Ms. PORTER. It came from Indian Health Service. The initial funding came from the mental health branch, not from alcoholism, because there was no money available in alcoholism.

It now is being funded, beginning this year, out of the alcoholism division of the Indian Health Service.

I guess it has been a very generic and generative kind of a process. What we propose is not a product. We don't have any answers that we are taking into communities. As Francisca mentioned, many times the work that we do to get a community ready will take 2 or 3 years to get them ready to begin, and they have to be ready. If they're not ready, we lose. We are running 100 miles an hour down a dead-end alley.

We are now working in three communities. We're working in the Southern Ute community in southern Colorado, the Mountain Ute community and the Navajo community in Canoncito. Canoncito is the one we have been working with the longest.

They have gone all the way through a process of developing comprehensive, long-range community plans around a philosophy for their community and a set of goals for their community that has wellness at its center.

This has been the model that most communities, not only Indian communities, but communities across the world have used. Every decision that is made in the community has to do with either the actual number of dollars or jobs that will be brought to the community. And one of the things that we have found is that very often that creates mental health and social problems that then emerge as tremendous pathologies just down the road. There are numerous examples of that in the Indian communities.

We propose to our communities that, instead of using this, that they use economic power as a tool to achieve wellness for their community. And so we take it out of the center and place it as one of the tools that we have to work toward the goals of our community. And then wellness becomes the filter through which all the decisions are made. So whether we're making economic decisions, political decisions or school decisions, this is the model that we use. And by doing that, our decisions are not shortsighted, they are carefully orchestrated, and they really begin to build a well community.

Ms. HERNANDEZ. The Southern Ute community has been the most willing, in terms of understanding, to follow this approach. There is commitment on the part of the leadership to do that. They are committed to making the changes. They are making small

every day decisions different from the way they have made decisions in the past.

For instance, they have decided, not to have alcohol or other chemical substances in some of their social activities in the community.

Chairman MILLER. Is Drug Busters incorporated as part of this, or as complementary to it? How does that work? Please identify yourself for the record.

Ms. VELASQUEZ. I'm Sue Velasquez, with Drug Busters. Our Drug Busters group started up about 2 year ago, and from that myself and another lady got involved in a panel that Francisca was talking about. But Drug Busters is primarily aimed at the young people. It was the young people themselves that were tired of what was going on in our community of Ignacio and saw a need to turn it around and make it positive, and they have done that.

There is an everyday struggle to keep going, but they have incorporated more and more children into that. One of the big things that they're running against is drug abuse, and that really incorporated all the community, the tribe, the school and the whole town. And for our community, that has worked.

Chairman MILLER. Toni, you mentioned some of the activities that you participated in with Drug Busters. Is part of this program also a social program to keep young people occupied and involved in activities?

Ms. RAEL. Yes, it has. Usually, I would be out and just doing nothing.

Chairman MILLER. We have talked to young people all week from different reservations from Seattle down to the Papagos. We spent a lot of time at a boarding school yesterday and on other reservations. What we saw was almost anger of the young at the boredom of reservation life. They absolutely had nothing to do. We talked to a large group of young people out on the Navajo reservation in one of the little villages. And outside of a Monday night movie being shown on a VCR and the one TV set that was available, there was nothing for these young people to do. They were trying to get activities going. And they said time and again that it was the boredom that just caused people to wander off and get into trouble simply because trouble became some form of excitement and deviation from the boredom, whether it was vandalism or whatever. Is that somewhat true of the Southern Utes?

Ms. RAEL. Yes.

Chairman MILLER. What do people do for recreation? Do you have a recreation center? Do you have programs?

Ms. RAEL. Not really. Well, now we do. It just used to be about 2 years ago we didn't. Now they have trips. We go to Durango. We go to the movies. We have other things. Sometimes in our church we do things.

Chairman MILLER. What year are you in school?

Ms. RAEL. I'm a sophmore.

Chairman MILLER. You're a sophmore? Do you live at home and go to high school?

Ms. RAEL. Yes.

Chairman MILLER. How many people live in your village? Is your school in your village?

Ms. RAEL. It's in Ignacio.

Chairman MILLER. Do you have to spend time on a bus to get there?

Ms. RAEL. Well, my mom drives me and my brother to school, but there is a bus that runs by our house.

Chairman MILLER. Now Drug Busters is what you're involved in, and you're creating a teen center also; is that correct?

Ms. VELASQUEZ. Alternative programs for the teens in our area. We had a recreation center in town that kind of fell by the wayside, but it is starting to pick up again. Our combined efforts have been in working with them in having different activities. During the Christmas break, when there was hardly anything for the kids to do, we had TV, movies, rap sessions at different people's houses just to keep them off the streets and out of trouble.

Chairman MILLER. Ms. Hernandez, would this be consistent with what you're trying to establish on the reservations?

Ms. HERNANDEZ. Yes, it is.

Chairman MILLER. We have been joined by Congressman Wheat, from Missouri, and we'll start questioning with Mr. Lehman.

Mr. LEHMAN. Thank you, Mr. Chairman. I just have a couple of questions. Most of what I've heard today could also be applied to the backwoods and the decaying farms in Appalachia, to the poor whites there. It could be applied to migratory farm laborers, such as we have in Belle Glade, FL. It could be applied to the homeless in our big cities, where people are sleeping under bridges in Miami and on top of grates in Washington. It could also be applied to the inner city public housing minorities where families are abandoned frequently by one of their parents.

What is the main difference between the problems of the Indians on the reservations and these other so-called fourth world types of communities that we have elsewhere in this country?

Chairman MILLER. Professor May?

Mr. MAY. That's the $64 million question. There are many common threads. There's no doubt about that. Poverty has been the one common denominator. Access to social means for advancement is certainly a common thread, too, but many of the things that are different have come up here.

For instance, Francisca mentioned racism. There is a degree of racism here in the west. It's not unlike the racism that I experienced in North Carolina and Maryland when I was there, but racism is one factor.

The second factor, I think, has to do with on reservations you have a residual population, in a sense. Many, many people have been pulled away from the reservation and they are out living in mainstream society, and we tend not to identify those folks as "Indians" any longer once they're off the reservation. Those back on the reservation, however, tend to be identified as Indians and, given their social isolation, generally are confronted with more problems.

So when we look at reservations, we sometimes are looking at a special-case situation. That is, you have more harsh, more deprived conditions. Therefore, it magnifies the problems that we see. But Indians are unique in that sense, and they have been subject to, as has been pointed out many, many times——

Mr. LEHMAN. I would like to put out a newsletter on this hearing and make the people I represent aware of this. If you could perhaps write me a memo as to what makes the problems unique, as you have stated, among the Indians and different from the ones that exist elsewhere among other kinds of deprived groups in this country, that would be helpful to me.

The only other thing that I would like to mention is about alcoholism and the lack of attention that this illness is given. Alcohol is socially acceptable throughout this country. It has been part of the frontier mentality. I am on the Appropriations Committee for Transportation that deals with the Coast Guard, and we fund the Coast Guard. We have received over $300 million from the Department of Defense to transfer to the Coast Guard, which is in the Transportation Department, to interdict illegal drugs that are not socially acceptable. And I think that is one of the sad factors. If the Indians would substitute cocaine for alcohol, you could get lots of Federal money.

Chairman MILLER. That is not a recommendation of this committee.

Mr. LEHMAN. I'm just saying that the way that our country looks at these problems, it is a sad fact that we do not recognize alcoholism and that alcohol is the most destructive drug we have, not only here, but elsewhere in the country. Thank you.

Chairman MILLER. Congressman Wheat.

Mr. WHEAT. Mr. Chairman, first let me thank you for holding the hearing. I apologize for being late. I got here as quickly as I could this morning.

Ms. Hernandez, perhaps you have discussed this already, and if so, if you could just summarize briefly for me, I would appreciate it. I was very interested in the model in the chart that you held up, which basically shows a completely different social order that you try to get communities to adopt. I would think that that would be a very difficult thing to do, and I recognize that it probably would take several years to get the community to a point where they would be able to accept a different social order. What are the things, very basically, that you have to do to get a community to a state of readiness?

Ms. HERNANDEZ. Most communities decide to do something about the problem when they have reached a crisis from which they don't know how to come out. At that point they usually call on us.

We do what we call a community intervention that will deal with the immediate crisis. When some kind of normalcy has been created, we begin our work with the tribal leadership. If the council accepts we go with the training for task forces and the design for a comprehensive community based prevention plan based on the strategy I outlined earlier. The goals of the plan include: Personal, familial and community reintegration; wellness and social development at the center of all community activities; school based prevention programming incorporated into school goals, activities and curriculums; community based programming for the development of basic skills.

One of the things I find most rewarding among Indian people is that they are tremendously enlightened and very willing to find some kind of meaning in their lives. This meaning was there once

and they are not that far removed from it; only confused. They are longing for that again.

And we help them understand that maybe things cannot be exactly as they were, but that they can define what they once had and incorporate what they can of it into a different reality today.

The most significant thing for success in this type of problem is to have a plan. Then you need to educate people and help them change their perceptions of themselves, their reality and the future. This is a process oriented approach. As their perceptions change they begin to feel more, to talk more, to trust more. Through dialogue and trust hope and optimism begin to gel and energy on action is generated. Our role then becomes more that of a guide. We encourage, empower, support, offer alternatives, help analyze, share what we know, affirm them, celebrate their successes. We have divided the work into a three pronged approach. One prong is treatment for those who are very sick people. They may be sick with a variety of things including alcoholism. Second prong is early identification and intervention for people who are becoming sick or who are at risk. For this prong we utilize schools, clinics and hospitals, courts, employment place and drivers as places where we can identify people early and intervene when they still have all systems going for them. The third prong is the prevention approach I have described already.

Mr. WHEAT. One of the things that you talked about, in terms of finding solutions, almost seems to be some kind of change in the spiritual essence of the community. And while I can understand that that would be very important and vital for trying to assist people who are having problems, I am not sure that I can see immediately what role government has to play in that process. Could you explain that to me, in terms of practical steps that we might be able to take back to Washington?

Ms. HERNANDEZ. These changes are not just spiritual changes. They represent fundamental social, personal and economic changes. The only spiritual dimension is the ability of people to reintegrate themselves and to create a new way of social, familial and economic life. We need both financial and philosophical support from our government. And right now we are in a state of crisis. For instance, our organization is about to be dismantled and eliminated because there are no funds.

Chairman MILLER. If I could interrupt on this point? What is the priority? What is the funding within the Indian Health Service for alcoholism?

Ms. HERNANDEZ. Maybe somebody else can help me with that.

Mr. MAY. Well, the vast majority, I'll bet, 95 percent of the money in the Indian Health Service that goes to the alcoholism programs goes to programs which deal with adult alcoholics, generally end-stage alcoholics. So they're dealing with chronic alcoholics.

Chairman MILLER. Is that for acute treatment or for prevention?

Mr. MAY. Generally for acute treatment and rehabilitation of those chronic alcoholics.

Chairman MILLER. So in effect they're taking the worst cases and dealing with them at the end of the syndrome and trying to decide whether or not they can rehabilitate them. Is there any kind of success rate?

Mr. MAY. There have been a number of studies, none too recent—well, there is one recent—and they are not too optimistic.

Chairman MILLER. On Congressman Wheat's point though, just as the Papagos and others suggested to us, there really is no money for preventive work on alcoholism for the reservations. That is what I was told by the Yakimas in Washington.

Mr. MAY. That's fairly true.

Chairman MILLER. How fairly true? Do you know of any big preventive programs that are sustained?

Mr. MAY. I can give you an example of mine. The National Indian Fetal Alcoholism Syndrome Program evolved out of pilot moneys, $120,000, which came forth in 1979, for the International Year of the Child. We did a 2½ year pilot project with a total of maybe $220,000. These were all special funds, they were not recurring. And it was obvious to a number of people in Congress, Congressman Yates specifically, that Fetal Alcohol Syndrome had tremendous promise because it was not dealing with end-stage alcoholics, it was dealing with a problem that could be entirely prevented.

Congress earmarked $300,000 for Fetal Alcohol Syndrome work, which we were able to compete for and get in 1983 $225,000. Now with that, we were——

Chairman MILLER. You don't leave a lot of change on the table, do you? Go ahead.

Mr. MAY. With that, we were mandated to train people in the prevention of Fetal Alcohol Syndrome on every reservation in the United States. So that's 93 Indian Health Service units, including 8 in Alaska, et cetera. So over a period of 2 years—we were able to stretch that—money to serve the entire Nation and we trained a large number of people. But those funds, again, were not recurring, so the project ended in October.

Chairman MILLER. And what happened to the people you trained? Was there funding for that program?

Mr. MAY. Only if local IHS people, which many of them were, were committed enough to write that in their job descriptions so they could continue.

Chairman MILLER. But they would have to be people who were already funded?

Mr. MAY. Right.

Chairman MILLER. There was no expansion of IHS personnel?

Mr. MAY. No. So what I'm saying is that's just one example of the fact that prevention moneys, as they are now called, in the past have been borrowed from some other source almost all the time. Francisca's program is an example.

So to sum it up, what she's saying is that prevention probably is a direction we should go in, because dealing with end-stage alcoholics is not very successful in any population.

Chairman MILLER. If you go to St. Michael's on the Navajo Reservation and you see the end stage of FAS with the children that are in that institution——

Mr. MAY. Exactly.

Mr. LEHMAN. Mr. Chairman, I have an idea of where we might find some money.

Chairman MILLER. That's why we always bring members of the Appropriations Committee along. We have all the good ideas, but no money.

Mr. LEHMAN. We fund the National Highway Safety Administration, which deals with the problems of driving under the influence and trying to prevent that. And you talk about your suicides, we find out that a lot of fatal highway accidents are really a form of suicide. You're probably not even counting them on your young people's suicides or the other suicides.

You can apply for some money from the National Highway Safety Administration to study the problems of alcohol-related accidents among the Indians in this part of the country. And in doing so, you might be able to gain some funds that you could spread around as a way to provide for highway safety. You might be able to get some money to deal with the alcohol problems of the Indians, and I will be glad to work with you on that.

Chairman MILLER. Congressman Wheat, I interrupted you.

Mr. WHEAT. That's all right, because your questioning did lead to the answers I needed.

Ms. PORTER. I just have one comment to follow up with here. The approach that we take is what we call a three-pronged approach. And you asked Francisca earlier if Drug Busters is part of what we're talking about. It is what we're talking about, but it is a very small part of what we're talking about.

When we're talking about creating well communities, we're really talking about transforming those communities. When we first started working on the problem, about 6 years ago, essentially what was in place were treatment programs. And as you can see, they deal with serious alcohol problems and alcoholics, very sick people. And as the chairman so aptly said, we're investing all of our dollars in this area, where the chances of us really having impact is very, very small.

At that time it seemed to us that the community transformation we're talking about was absolutely critical to the future of the communities, and that's this prong over here. But the thing we found as we tried to work in that was that the communities were in such crisis that, unless we found some effective way to alleviate the crisis, that they couldn't think about this because this is very long range.

So as a consequence, we created this middle prong. And in the middle prong what we are trying to do is identify people in the early stages.

So the thing we said to ourselves, knowing what the money situation was and also the way that we believed in incorporating all the people in a community into believing that alcoholism is preventable and that they have a role in preventing it, we said, "Where are people in the community seeing the problem, but doing nothing about it because they believe that it isn't their responsibility, or they fear doing it because they don't have enough information or they're stepping on somebody's toes?"

The areas that we found where people were seeing it and not doing anything about it were essentially in the courts, with legal offenders. We had major offenses in the community. It is not uncommon to see between 90 and 100 percent of those offenses be al-

cohol related. We weren't making any tie-ins there, and we weren't doing anything about alcohol as an initiating factor.

The other places where people were seeing the problem and not doing anything about it were in clinics and hospitals. The trauma was being treated and the pathology was being treated, but the new traumas were being ignored.

The other place was drivers. DWI rates in New Mexico are higher than any place in the United States, and yet we were not making any connections and any direct feed-ins between what was happening there and the alcohol programs.

The other places where people were seeing problems were among students. Students, young people, spend most of their waking hours in school, and it becomes very obvious when there are problems. But because people are not equipped to deal with those problems, they do nothing about them.

And finally, the other place was in the workplace. Places where people see each other on a very regular basis are the first places where the signs and symptoms of problems occur.

Our belief was that if we could develop programs in these areas and identify people early and intervene in the problems, that we could have outcomes that would far exceed this, with much fewer resources, many fewer resources.

So recognizing that, we created programs in all of those areas, first offenders' programs. We have a project to define the role of a physician in the early identification and intervention in alcoholism. We have DWI legal help programs. We have student assistance programs and employee assistance programs. And we have the technology, a technology that is very sophisticated, in every one of those areas. The problem has, again, been funding——

Chairman MILLER. Let me stop you. Toni, let me ask you a question. Do you have a setaside of title XX funds for Indians in this State?

Ms. MARTORELLI. Yes, we do.

Chairman MILLER. So that's related to the population of title XX eligible in the State? How is that done; do you know?

Ms. MARTORELLI. If you don't mind, could I refer that question——

Chairman MILLER. You can submit it to us in writing. One of the things we have discovered is States handle title XX differently. In some States Indians are counted for the purpose of receiving title XX funds, but then it's not disbursed. You know, it's not passed through or set aside. Arizona sets it aside, and New Mexico, you said, also sets it aside.

Let me ask you this. The Navajos testified that they are working out a procedure with the State for licensing for out-of-home care under the Indian Child Welfare Act. Do you know if any negotiations are going on between the Indian tribes here, the tribal councils and the courts, to start placing Indian children, and to get IV-E money?

Ms. MARTORELLI. I know that we've done some work in IV-E, and I don't have the specifics on the activities going on in the State, and I will be glad to submit those to you.

Chairman MILLER. I would appreciate that. Again, because it appears, with the overwhelming concerns that have been raised re-

garding Indian child welfare, that it is very difficult, nearly impossible, to get any of the maintenance money once the tribes have made a decision about the placement of a child out of home, and they then have to start through the State system just for the purpose of funding. It seems to me that that's a rather large waste of both the State system's time and a denial of the tribe's right to make decisions about the placement of these children. So I would appreciate it if you would submit to us what the situation is or what you're working on. And I don't know if the Navajos are also working on it in this State, as they are in Arizona, but that would be very helpful.

Ms. MARTORELLI. I can do that.

Chairman MILLER. Finally, I would just like to ask Toni and Danielle about the use of alcohol among their friends. Do you see it quite often?

Ms. MONTE. Yes.

Chairman MILLER. You are what age now?

Ms. MONTE. I'm 13.

Chairman MILLER. You're 13? What's the youngest of your friends or their brothers and sisters that you might see using alcohol?

Ms. MONTE. Probably 10 years old.

Chairman MILLER. Ten years old?

Ms. MONTE. Yes.

Chairman MILLER. Is that unusual or not so unusual or——

Ms. MONTE. I think it's unusual.

Chairman MILLER. It would be unusual at that age? What about when you're 13, 14, 15?

Ms. MONTE. Probably unusual.

Chairman MILLER. So when you see it among young people, the use of alcohol, would it mainly be boys or girls? Would it mainly be 16 or 17?

Ms. MONTE. I'm not too sure about that.

Chairman MILLER. Toni, what do you think?

Ms. RAEL. I don't think it's very uncommon, because I see a lot——

Chairman MILLER. It's not uncommon?

Ms. RAEL. No. I see a lot of younger, really young people.

Chairman MILLER. Like how young?

Ms. RAEL. Ten, but that's really young to me.

Chairman MILLER. That would be unusual, that young, but you've seen it or heard about it?

Ms. RAEL. Yes.

Chairman MILLER. Some of the reservations, I hate to say, were even discussing—the young people were saying that they were aware of people substantially younger than 10 who they thought had trouble with alcohol.

Ms. RAEL. I don't think they're really addicted, but I think they have had experience with it.

Chairman MILLER. Do young people discuss it? Do you talk about the problems that it creates?

Ms. RAEL. Yes, we do. Sometimes we joke about it. Sometimes we're really serious about it in our meetings.

Chairman MILLER. In your discussion groups with Drug Busters? What about discussions in terms of the use of alcohol within families? Do young people talk about their parents' alcohol problems or grandparents?

Ms. RAEL. In health, we do.

Chairman MILLER. Is that a major problem for young people, alcohol in their homes?

Ms. RAEL. I don't really know.

Mr. LEHMAN. Mr. Chairman?

Chairman MILLER. Yes.

Mr. LEHMAN. Both Toni and Danielle, you are young women with Drug Busters. There are no young men from Drug Busters here. Is your organization predominantly young women, or are you also able to include an equal proportion of young men in your organization?

Ms. MONTE. It's mixed.

Mr. LEHMAN. It just happens that there are two young women here, but it's half and half?

Ms. MONTE. Yes, about half and half.

Chairman MILLER. What is the closest large city to the Southern Utes' pueblo?

Ms. VELASQUEZ. It's Durango.

Chairman MILLER. Durango?

Ms. VELASQUEZ. The next big city is either Albuquerque or Denver.

Chairman MILLER. And what is the distance to Durango?

Ms. VELASQUEZ. Twenty-six miles.

Chairman MILLER. How often do the young people go into Durango?

Ms. VELASQUEZ. Well, our group, we try to take them at least three or four times a month.

Chairman MILLER. So that's part of your activities?

Ms. VELASQUEZ. Right.

Chairman MILLER. I'm just trying to get a picture of it. It obviously changes from reservation to reservation. Yesterday, in talking to the Papagos, I don't think any of the young people we talked to could remember the last time that they were in the vicinity of Phoenix, which is a fair drive, but can be done. And again, it was one of the concerns that they had that they felt they were totally isolated. I know some portions of the tribe think that's good, but an awful lot of the young people do not. They used to have field trips, but no longer do because of the lack of funding in the BIA schools.

Thank you very much, everyone on the panel. We appreciate your contributions, and I suspect that you will find out that the committee and myself will be back to you as we start to think of some ways to solve some of the impasses. Thank you very much.

The next panel will be made up of Floyd Solomon, who is a parent and a parent trainer in Education for Indian Children with Special Needs, from the Laguna Pueblo; the Honorable Stanley Paytiamo, who is the Governor of the Pueblo of Acoma, NM; Marjorie Reyna, who is the executive director of the Division of Economic Development, Navajo Nation, Window Rock; Bennie Cohoe, the executive director of the Ramah Navajo School Board, Pine Hill, NM; and Melinda Bronson, who is the director of tribal social

services for the Ute Mountain Ute Tribe, Towaoc, CO. If you will come forward to the witness table.

As you can see, your testimony generates a number of questions from members of the committee. So again, whatever written statements you have prepared will be included in the record in their entirety. To the extent that you can summarize will be most helpful to us so that we will have time to allow for questions. But I also want you to proceed in the manner in which you are most comfortable. And again I want to thank you very much for your time and effort to join us. Mr. Solomon, we will begin with you.

STATEMENT OF FLOYD SOLOMON, PARENT AND PARENT TRAINER, EDUCATION FOR PARENTS OF INDIAN CHILDREN WITH SPECIAL NEEDS, LAGUNA PUEBLO, NM

Mr. SOLOMON. I would first of all like to begin by welcoming you to New Mexico. My name is Floyd Solomon. I would like to tell you a little bit about my son, on whose behalf I am speaking.

My son, Travis, was born January 29, 1979. He is presently 6 years old and in the first grade. In school, he is functioning at average to above average in all areas except speech and language development.

Travis is handicapped. He is hearing impaired, with a severe-to-profound hearing loss. He wears hearing aids on both ears. The cause of his hearing loss is unknown. Travis has been receiving audio-verbal therapy in Albuquerque for the past 3½ years.

At age 2½, there were indications of Travis' speech delay. It took 1 year of examination and testing before he was diagnosed and another 6 months before he was properly fitted with hearing aids.

The delays were a result of a lack of appropriate audiological equipment, including a soundproof booth, at the local IHS area hospital, and the Albuquerque IHS auditory testing facility was under renovation. We were unaware that IHS had the ability to contract these services with private providers.

After 1½ months of speech-language therapy, the IHS audiologist recommended more intensive therapy and referred him to a private oral program in Albuquerque. We wanted to try an oral program with the hope that our son could attend school and communicate as a hearing child in our community.

We drove him 100 miles round trip from our home in Laguna to Albuquerque for therapy. Initially, that was five times a week. Now it is two times a week. The amount of therapy has been lessened, due to the financial hardship of my family. We pay the costs of therapy and transportation ourselves. My wife quit her job so that she could drive him to therapy classes. We were not informed of any sources of financial assistance. Only recently did we learn that we were and are eligible for SSI, which is supplemental security income, and it is under a State program.

Neither the Head Start Program nor the BIA schools in which he has been enrolled in our community have been able to coordinate their efforts effectively enough to provide the audio-verbal therapy Travis needs. We paid for private educational diagnostic services to evaluate our son and give the results to the school.

Our community BIA school has recently hired a speech-language pathologist with a bachelor's degree and no previous education or experience in working with a child like Travis, with a severe-to-profound hearing loss.

Although we have a signed IEP, my son is still not receiving therapy from the school. Last year, the school promised to contract services with the Oral Program where our son receives therapy. So far, that hasn't happened. We continue to pay for and transport our son to Albuquerque for the audio-verbal therapy he needs.

As the parent of a handicapped child, I have learned to function as a teacher, a therapist, a case manager and a legal advocate. I must arrange transportation, diagnostic services, and financial assistance. I need to be knowledgeable of the laws and procedures for ensuring that my child's rights are upheld.

Because of my firsthand experience and the frustration that my family has encountered due to poor coordination and lack of communication between service providers, I have become involved in parent support organizations in New Mexico.

More recently, I have formalized my commitment to helping other parents with handicapped children by taking a position with a new project which provides education and training to Indian families with disabled children. The project is called EPICS, Education for Parents of Indian Children with Special Needs. It is part of a national network of parent support programs supported by the U.S. Department of Education, Office of Special Education and Rehabilitation Services. The two main goals of the project are to educate and train Indian parents to become advocates for their child's needs and to establish a network of parent support groups in the Indian communities.

This project will help families to constructively share and use information. Although each child's needs are unique, the needs of parents are similar. By working together, parents can hopefully become more adept and effective in addressing major problem areas. Thank you.

Chairman MILLER. Thank you. Governor Paytiamo.

[Prepared statement of Floyd Solomon follows:]

PREPARED STATEMENT OF FLOYD SOLOMON, PARENT AND PARENT TRAINER, EDUCATION FOR PARENTS OF INDIAN CHILDREN WITH SPECIAL NEEDS, LAGUNA PUEBLO, NM

My name is Floyd Solomon, I'd like to begin by telling you about my son on whose benefit I am speaking.

My son Travis was born January 29, 1979. He is presently six (6) years old and in the first grade. In school, he is functioning at average to above average in all areas except speech and language development. Travis is handicapped. He is hearing impaired with a severe to profound hearing loss. He wears hearing aids on both ears. The cause of his hearing loss is unknown. Travis has been receiving speech therapy in Albuquerque for the past 3½ years.

At age 2½ years, there were indications of Travis' speech delay. It took one (1) year of examinations and testing before he was diagnosed and another six (6) months before he was properly fitted with hearing aids. The delays were a result of a lack of appropriate audiological equipment including a sound proof booth at the local IHS area hospital and the Albuquerque IHS auditory testing facility was under renovation. We were unaware that IHS had the ability to contract these services with private providers.

After 1½ months of speech-language therapy the IHS audiologist recommended more intensive therapy and referred him to a private oral program in Albuquerque.

BEST COPY AVAILABLE

We wanted to try an oral program with the hope that our son could attend school and communicate as a hearing child in our community.

We drove him one-hundred (100) miles round trip from our home in Laguna to Albuquerque for therapy. Initially, that was five (5) times a week, now it is two (2) times a week. The amount of therapy has been lessened due to the financial hardship of my family.

We paid the costs of therapy and transportation ourselves. My wife quit her job so that she could drive him to therapy classes. We were not informed of any sources of financial assistance. Only recently did we learn that we were and are eligible for SSI.

Neither the Head Start Program nor the BIA schools in which he has been enrolled in our community have been able to coordinate their efforts effectively enough to provide the speech and language therapy Travis needs. We paid for private educational diagnostic services to evaluate our son and give the results to the school.

Our community BIA school has recently hired a speech-language pathologist with a Bachelor's degree and no previous education or experience in working with a child like Travis with a severe to profound hearing loss. Although we have a signed IEP, my son is still not receiving therapy from the school. Last year, the school promised to contract services with the oral program where our son receives therapy. So far that hasn't happened. We continue to pay for and transport our son to Albuquerque for the speech-language therapy he needs.

As a parent of a handicapped child I've learned to function as a teacher, a therapist, a case manager and a legal advocate. I must arrange transportation, diagnostic services and financial assistance. I need to be knowledgeable of the laws and procedures for ensuring that my child's rights are upheld.

Because of my first hand experience and the frustration my family has encountered due to poor coordination and lack of communication between service providers, I've become involved with parent support organizations in New Mexico.

More recently I have formalized my commitment to helping other parents with handicapped children, by taking a position with a new project which provides education and training to Indian families with disabled children. The project is called EPICS, Education for Parents of Indian Children with Special needs. It is a part of a national network of parent support programs supported by the U.S. Department of Education, Office of Special Education and Rehabilitation Services. The two main goals of the project are:

To educate and train Indian parents to become advocates for their child's needs and;

To establish a network of parent support groups in the Indian Communities.

This project will help families to constructively share and use information. Although each child's needs are unique, the needs of parents are similar. By working together parents can hopefully become more adept and effective in addressing major problem areas.

STATEMENT OF GOV. STANLEY PAYTIAMO, GOVERNOR, PUEBLO OF ACOMA, NM

Governor PAYTIAMO. Chairman Miller, members of the select committee and staff, my name is Stanley Paytiamo and I am the Governor of the Pueblo of Acoma. I also have with me Lt. Gov. William Estevan, who will use some of my time.

As you indicated, the unemployment rate is high on the reservations. Our unemployment at Acoma is 78 percent. The county had a large uranium industry, and that has closed down. In the Grants area and vicinity, we have lost about 2,000 people that have moved out, and we all know that we need to provide a way of economic development.

The people are always shooting down Indian bingo. We have a bingo operation on the Acoma Reservation. People are trying to pass legislation to say that Indians cannot have bingo on the reservation. What if I said that I would like to put the alcohol industry out of business? How would they feel? You know, they depend on

BEST COPY AVAILABLE

their economic development and we also depend on bingo as our economic development on the reservation.

You have my testimony, and I'm not going to go through it. As it was supposedly indicated concerning the suicide rate, we have a service unit, called the Acoma/Canoncito/Laguna Service Unit. This service unit has the highest suicide rate in the State. We are trying to use the judicial system as support, but there currently exists a problem with my tribe obtaining services from State agencies. The State and Federal Governments continue to argue between themselves. The State and the Bureau of Indian Affairs are always going in opposite directions. There is a long waiting list for services that the Indian people cannot get.

The Acoma people have a very high handicap of tribal members because of FAS, and FAS is unknown to the Indian people. We need to have some education on that. You know, where does that thing come from?

And also, I would like to point out that the people at the Washington level have put labels on cigarette smoking, that it is hazardous to your health, that it can be hazardous to your health. I would like to see legislation be started to put labels on alcohol. I can't understand why they put, "May be hazardous to your health," on cigarettes. I can't see what damage is done. But most of us know that we can see evidence all around about what damage is done by alcohol, the use of alcohol. We have a high rate of DWI. I'm glad to say we are doing something about that. Everybody is organizing to fight the DWI people.

And also I feel that there is a great need for better cooperation between the Indian Health Service and the Bureau of Indian Affairs.

We also need to prepare our children through quality education. The Bureau of Indian Affairs and the public school system are not providing the quality of education we need to see that people are prepared for the future.

And also, we talk about funding. It is the position of the Pueblo of Acoma that the U.S. Congress has a trust and treaty responsibility to the first Americans, to the Native American, which supersedes the vast reductions scheduled under the Gramm-Rudman Act. We are eager, as Indian people, to terminate the dependency on the Federal bureaucracy, but this cannot be accomplished without an appropriate stage of development, both economic and human development.

In the interim, we suggest that the Federal funds be channeled directly to the tribes and that we be given a chance to prove what we can do. This reprogramming could save dollars for the Government.

In closing, I would like to say that we have attended many, many hearings of this kind, I would say maybe in the last 5 years, and we keep saying the same things and we keep singing the same songs. I hope that maybe a rock and roll group will put it to music. Maybe somebody then would hear us. This was done, you know, with the OPM, when people started putting music to feeding the hungry, and somebody got some attention. Maybe if we could do that, maybe somebody would do something in the area of alcoholism prevention. I think that's what we need to do.

I think all we're doing right now on some of the cases is that, you know, we're trying to take care of the chronic alcoholic, and we're not doing very much in the area of prevention. I think we needs to do a lot more work in community education and prevention so that we don't have to take care of all those substance abuse people.

And also I think there is a need, a great need. I think some people put recreation on a very low priority. We talk about trying to do something for the idle youth, but there are no funds for developing recreation programs. Also, in the area of title XX I understand that there may be, I think, only one Indian tribe that is funded under title XX through the State, and I think there needs to be more of those types of funds available to the Indian tribes.

Also in the area of mental health, I am aware that there is only one pueblo that is funded for mental health, and there needs to be more mental health programs developed for the tribes.

This concludes my remarks, and I will be glad to answer any questions. I would like to allow the additional time that I have to the First Lieutenant Governor. Thank you very much.

[Prepared statement of Gov. Stanley Paytiamo follows:]

PREPARED STATEMENT OF GOV. STANLEY PAYTIAMO, GOVERNOR OF THE PUEBLO OF ACOMA, ALBUQUERQUE, NM

Chairman Miller, members of the Select Committeee and staff, my name is Stanley Paytiamo and I am the Governor of the Pueblo of Acoma which is located 60 miles due west of Albuquerque.

I greatly appreciate this opportunity to address the needs of my Acoma children and families. I am confident that our situation is similar to the many other tribes you have heard from over the past few days. However, I like to think that the Pueblo of Acoma, as a traditional community, is also unique in many ways.

Our traditional village, known to the non-Acoma as "Sky City," is recognized as the oldest continously inhabited community in North America. Hak'u, as we call it, is situated atop a 365' mesa and Hak'u in our own language means "a place prepared for the people," and is listed as a national historic landmark by the Federal Government.

In many respects, "preparation" should be a main focus of your committee because that is a family's primary responsibility—to prepare the children for the future.

Before I address the current status of our families, I would like to give you some data on our community. Our population is approximately 4,139 people with 75% living on tribal lands. Our per capita income is $2,987 (Bureau of Census—1980) and our unemployment rate approaches 78%. Sixty-two percent (62%) of our population is below the age of 26 years. Most of our community members live in the communities of Acomita and McCartys and participate in some form of agrarian activity, either farming or raising livestock, to supplement their income.

The Pueblo of Acoma is located in Cibola County which has been hard hit by the collapse of the uranium industry. In 1970, the population of the county was 40,539. The 1980 census indicated that the county population had dropped to 30,437. Since 1980, almost all uranium operation has been shut down and the county population has further declined to approximately 20,000 individuals. Clearly the surrounding community is as hard pressed as we are here at the Pueblo of Acoma for economic survival. As this committee knows, such economic conditions place a very damaging strain upon the family and its ability to raise and prepare its children.

Our children are being affected by much the same trends which are impacting children throughout this country: the use and abuse of drugs and alcohol; teenage pregnancy; the lack of basic educational skills and the lack of job training and opportunities. Teenage mortality rates for the Indian child are 33 percent to 50 percent higher than the non-Indian largely due to motor vehicle accidents. Our parents, even more so than most parents, are not adequately prepared to address these problems.

BEST COPY AVAILABLE

The strength of our community are our traditional values and practices. More than eighty percent (80%) of our population is full-blooded Acoma and continue to participate in our traditional way of life. We believe that these values and practices of our forefathers are not only useful, but necessary in the preparation of our children. In this sense, the Pueblo of Acoma is known as one of the traditional Indian communities in the Southwest.

Our tradition alone however, cannot relieve the economic strain that is felt by each of our families nor can it fully prepare our children for self-sufficiency in the outside world. The Pueblo of Acoma has aggressively approached the need for economic development over the past years and we will continue in this direction. It has been through the efforts of the Tribe that we have reduced unemployment by 12%. We have implemented the taxation of companies operating on tribal land. We are in the initial stages of developing a multi-million dollar project to be located on Interstate 40. It is estimated that this will reduce the unemployment rate by 50%. As you can see we are trying to do our part in addressing some of our economic needs and because we realize what our responsibilities are, we stress the family's responsibility to prepare the child for the future and the tribe's responsibility to prepare future jobs. In this endeavor to increase economic development we need to develop and strengthen our partnership with the County and State.

There currently exists a problem with my Tribe receiving services from State Agencies. The State and the Federal Government continue to argue between themselves in regard to responsibility and the Indian people are denied services. Acoma has an inordinately high rate of handicapped members in relation to the national average. We have submitted a proposal to the Department of Health & Human Services to help develop in-home services to families with developmentally disabled members. Due to the extremely rural location of Acoma, we do not have the option of developing partnerships with corporations or other companies to help share in the cost of meeting the needs of my people.

I feel there is urgent need to coordinate and improve services provided by the Indian Health Services (IHS) and the Bureau of Indian Affairs (BIA). These federal agencies are working separately thus resulting in the duplication of some services and the omission of others. Increased communication and an effort to work as a cohesive unit would greatly improve the quality of services provided without costing the Federal Government any extra dollars.

We need to aggressively prepare our children through an appropriate and quality educational system. Our children are not obtaining the basic skills they need in either the BIA or public school systems. A student who graduates from high school without a functional ability to read is being prepared for failure.

The Pueblo of Acoma is addressing the comprehensive educational needs of our people from preschool through adult education, but the resources are limited and shrinking. We are concerned with the administrative changes which have taken place within Project Head Start which have had an adverse impact upon all Indian children. We are concerned that the federal budget will be balanced on the backs of my Indian children and their families.

It is the position of the Pueblo of Acoma that the United States Congress has a trust and treaty responsibility to the first Americans, to the Native American, which supersedes the vast reductions scheduled under the Gramm-Rudman Act. We are eager, as all Indian people are, to terminate the dependency upon the federal bureaucracy. But this cannot be accomplished without an appropriate stage of development, both economically and human development. In the interim we suggest that federal funds be channeled directly to the Indian tribes and give us a chance to prove what we can do. This reprogramming could save dollars for the government.

In closing, I would like to express my sincere gratitude, on behalf of my people of Hak'u and the Pueblo of Acoma Tribal Council, that the Select Committee has taken the time to visit the Southwest and hear our concerns. If your schedule allows, I invite you to visit "Hak'u" and our other communities this afternoon.

Thank you.

STATEMENT OF WILLIAM ESTEVAN, FIRST LIEUTENANT GOVERNOR, PUEBLO OF ACOMA, NM

Mr. ESTEVAN. Thank you, Governor, Chairman Miller, and the rest of the delegates that are here.

The only comments that I can add to what Governor Paytiamo has said, I think it holds true for our community that it is no dif-

BEST COPY AVAILABLE

ferent than any other Indian community in the State, as well as nationwide. We have similar problems.

But I think one of the things that I need to allude to is the fact that we are one of the tradition-oriented people in this State, and we continue to hold on to the community life in the traditional sense very much so today. And I think one of the things that we really need to do within our own community is to educate the surrounding communities and people in that sense.

Also, one of the things that is unique within our situation is that we are very much trying to educate our own youth in self-identity as Indian youth. A lot of times when they don't have a good stance on who they are and where they come from and who their grandparents are and how the community's way of life is, a lot of times it leads them to start to wonder, "Who and where and what do I belong to?"

So with that, I think one thing that's certain is it has led many of our community youth in that direction, in the sense that they have started to go back into the kiva, which is a ceremonial chamber within our pueblos, and start to participate in the ritual dances and religious activities of the elders, and they start now to participate with the tribal elders in doing interviews and talking among themselves to find out what they had to do when they were young people.

I think it's very true a lot of times that a communication gap is there. But with this type of program that we have within our own school system, I think we're starting to open avenues that are starting to lead to participation in our own communities in many ways, and there are many different things that we hope to improve on. I think we are doing our share, but I think with the help of State government and the Federal Government, we can continue to address these problems. But we certainly stand ready to try to address these problems from a leadership standpoint. Thank you for your time, Mr. Chairman.

STATEMENT OF MARJORIE REYNA, EXECUTIVE DIRECTOR, DIVISION OF ECONOMIC DEVELOPMENT, NAVAJO NATION, WINDOW ROCK, AZ

Ms. REYNA. Mr. Chairman, Mr. Lehman, Mr. Wheat, my name is Marjorie Reyna. I am the executive director of the Navajo Nation Division of Economic Development. I would like to express my appreciation to you for taking the time to come out to our reservations to learn firsthand what exactly the tribes have to cope with in the area of socioeconomic conditions and social problems as they relate to economic development on our reservation.

Like any other society and community, the Navajo Nation, as well as other Indian tribes throughout the United States, has tremendous economic and social problems, including high unemployment, low per capita income, child abuse, teenage pregnancy, school dropouts, disruptive family and homes and a high suicidal rate. The statistics reflect that these problems are much more evident on Indian reservations than they are in other societies. As in any other society these social problems are the result of the poor economy conditions. I would like to speak specifically on how these

social problems evolved on the Navajo reservation and what the Navajo Nation is trying to do to cope with those problems.

Until the imposition of the Federal Government on our reservation in 1868, the Navajo people were extremely independent people. Economically, we were a self-supporting people, and we didn't have the types of social problems that are evident on our reservation today.

As we evolved into a new generation, we found ourselves becoming more dependent on the Federal Government. We found ourselves developing into a welfare society. We had our economic development base taken away from us through livestock reductions and controls. We found a whole new foreign lifestyle forced upon us.

As a result, our family lifestyle was disrupted. The sense of pride and strong family ties gradually disappeared. We found ourselves living in a society with which we did not know how to cope.

We also lost a substantial portion of our economic base—land—and at the same time we had to deal with destructive social and cultural changes in society. It is really unfortunate that these problems have caused a dramatic family change in the family structure throughout our reservation.

This is a very critical problem because we don't have enough job opportunities on our reservation. Our unemployment rate is around 32.7 percent, but that is a little bit misleading. In some portions of our reservation it's as high as 90 percent.

In order to get a better perspective of the present economic situation on our reservation, you have to understand the basic economic structure of our reservation. We are the largest Indian reservation in the United States. We cover approximately 24,347 square miles, in Arizona, New Mexico, and Utah. We have a population of 162,000 growing at the rate of 2.5 percent per annum. Our per capita income on the Navajo Nation is $2,400. The U.S. 1980 census shows that 51,900 of our people are below the poverty level. We are a very young nation. Approximately 50 percent of our people are under the age of 25.

The economic climate on our reservation is extremely underdeveloped. Our living conditions are poor. Approximately 70 percent of our households live in substandard homes, which have no electricity, no running water, no sewer facilities. Further, the Navajo families are forced to spend at least 30 percent of their disposable income on transportation and commuting expenses because of the remoteness of our reservation.

Our reservation is approximately the size of West Virginia. However, if you look at our roads on our reservation, the mileage of paved roads is not even equal to one-twentieth the mileage of paved roads in West Virginia.

Mr. LEHMAN. One-twentieth.

Ms. REYNA. One-twentieth. And when you look at the funding that comes through the Department of Transportation—I will mention this, Mr. Lehman, because you mentioned you are on that committee—when the 5-cent tax was imposed on gas throughout the United States, I became very familiar with that particular law, and it did state that these are additional funds that are coming through the different States, as well as reservations. When the

Navajo Tribe received that money, the money coming through the Bureau of Indian Affairs was decreased, so we never did receive any net increase in available road funds that came through that increase in the Federal gasoline tax.

Mr. LEHMAN. That was 4 cents. It was a 5-cent tax. One cent was going to the United States, and the other 4 cents was going to be applied to the interstate and other highways. But the Indian reservation did not receive any of those additional support funds?

Ms. REYNA. That's correct. While the money did come down, a decrease was realized in the BIA money that we were getting for transportation and improving our road system, so it netted out to zero. We didn't get any additional moneys at all.

The major industries on our reservation are government, construction, utility companies, retail trade and mining. I would like to point out that 76 percent of our economy is supported by the public sector. The Navajo Nation's desire is to turn this around.

We are encouraging private sector development on our reservation. We are very aggressively pursuing a self-sufficient economy on our reservation, and we have taken tremendous strides over the past few years to start gaining control of development on our reservation.

We are implementing a tax base. We are renegotiating all of our mineral leases. We are streamlining the cumbersome business regulatory system that presently hinders development on our reservation. We are establishing a solid financial base. We are working toward the development of an industrial base on our reservation. There are many things that we are doing.

However, the new direction that is taking place in our Federal Government and the decrease in funding that is affecting every society throughout our Nation is certainly hindering our reservation. And I would like to state that any more we don't look toward the Federal Government for handouts. We really look toward the Federal Government to work with us, to support us, to give us continuing commitments. We look toward the Federal Government to work with us on a partnership basis.

We are starting to use the moneys that are now coming to the reservation through the different Federal programs in a leveraging approach to our development. We use it not only with our own money, but with private money, as well, in the development of different projects on the reservation.

Our whole philosophy on developing our economy is to have a lifestyle that provides our people with a choice of how they want to live. Our intent is to provide jobs for our people. Our intent is to bring our young people back to our reservation and provide incentives. We have about 60,000 young Navajos who graduate from high school each year. It is our responsibility to find jobs for those young people, and that is basically our ultimate goal.

That really sums up what I have to say to you today. I really would like to emphasize to you that this isn't the time to cut funding to the Indian tribes. We're just beginning, and I think that for the first time we are taking steps in the right direction, and we need to keep that continuing support coming to us.

Just briefly, we count on EDA money, we count on HUD money, we count on ANA money, we count on BIA money. We use these,

and we are very effective in getting some projects going. We are very concerned that much of the funds are drying up, and I think now isn't the time to stop bringing it to us. We need you to continue to bring it. Thank you.

Chairman MILLER. Thank you. Mr. Cohoe.

[Prepared statement of Marjorie Reyna follows:]

PREPARED STATEMENT OF MARJORIE REYNA, EXECUTIVE DIRECTOR, FOR THE NAVAJO DIVISION OF ECONOMIC DEVELOPMENT, THE NAVAJO NATION, WINDOW ROCK, AZ

My name is Marjorie Reyna. I am the Executive Director for the Navajo Nation Division of Economic Development.

Mr. Chairman, distinguished members of the House Select Committee on Children, Youth and Family, on behalf of the Navajo Nation, I would first like to express my appreciation to you in conducting these hearings that will determine not only the crux of the problems faced by the Navajo family, its youth and children, but identifying as well, solutions for rectifying these same problems. Like any other society and community, the Navajo Nation also has its share of social problems; problems related to high unemployment, low per-capita income, child abuse, teenage pregnancy, school drop-outs, drug and alcohol abuse, disrupted family and homes, and high suicidal rates. Statistics reflect that while these problems parallel to other societies, they are evident on a much larger scale on the Navajo reservation as well as most other Indian reservations. I believe that this is an already well documented fact that will again be made evident through the course of your research and findings. My presentation will reflect the causes of these problems as they relate to the Navajo Nation economy and how the Nation is addressing the situation.

To be sure, the social problems are directly related to state of the economy in any setting. Causes of these social problems can better be understood by looking at the socio-economic and political structure of the Navajo Nation in a historical perspective, and the changes that have taken place over the course of the past 100 years. Navajo history shows that Navajo families were traditionally a self-supporting and independent people, free from the burdens and problems related to outside society. The Navajo had their own identity, culture, freedom, economic base and self-governing system. This lifestyle existed until such time the U.S. federal government imposed its own governmental sanctions and laws upon the Navajo people through the signing of the treaty in 1868. Certain promises were made to the Navajos at that time by the federal government which included promises for economic opportunities as well as provisions for health and educational programs. The federal government's structure of its role as the Indian "Trustee" in essence converted the role of the Navajos into that of public wards of the government.

Further restrictions during the early 1900's were placed upon the Navajos through livestock reduction and controls, and ultimately the self-supporting lifestyle of the Navajo family eroded to that of an almost total dependency on the federal government. The Navajo cultural lifestyle and its language were planned for termination with the "American" lifestyle and society to be imposed on the reservation.

These dramatic changes to the Navajo family caused a sense of loss of identity through these disrupted social and cultural changes in society, consequently causing an evolution of the Navajo family: All generations of Navajo people are plagued with a variety of social problems that previously were entirely foreign to the Navajo people. The loss of land also resulted in loss of the means of livelihood for many Navajos. Forced to assimilate into a new cultural and social behavior, they began to lose their value system along with a loss of close family ties. This was a major contributing factor to the subsequent social problems, as mentioned herein. Unfortunately, these social problems have taken root in the Navajo family and are now prevalent throughout our reservation.

In essence, our generations of Navajos have turned into a dependent society which is economically weak and reliant upon federal government hand-outs that allow minimal family survival for a predominant number. These problems can largely be attributed to the underdeveloped economy of the Navajo Nation. No jobs and no hope for jobs has lowered the Navajo youths' self esteem. This type of bordertown economy lent itself to Navajo migrations to bordertowns placing substantial burdens on these towns as well, evident in social problems, alcoholism, unemployment, etc.

In order to get a better perspective of the present economic situation of the Navajo Nation, one has to understand the basic economic structure of the reservation. The Navajo reservation encompasses a land base of 24,347 square miles extend-

BEST COPY AVAILABLE

three states; Arizona, New Mexico and Utah. It is the largest of all U.S. Indian reservations. As of 1985, total population of the Navajo Nation is over 167,000 which is growing by a rate of 2.5% annually. The Navajo population is expected to surpass 200,000 substantially by the year 2000. The 1980 Census indicates that the median age of the Navajo population is 18.8 years with 50.4% of the population being under the age of 19 years. An average of 5.4 persons reside in one household. Per capita income of the Navajo Nation is $2,414 and the median household income is $8,342. U.S. 1980 Census showed that 51,904 Navajos residing in the Navajo Nation were classified as below poverty level and to this date this number has not changed very much. Present unemployment rate of the Navajo Nation is 32.7% which is supposed to have improved compared to the past, but it is unbearably high compared to the National economic standards.

The infrastructure and economic climate of the Navajo Nation is virtually undeveloped, living conditions are poor, and approximately 70% of households live in sub-standard houses which have no electricity, running water or sewer facilities. Further, Navajo families are forced to spend at least 30% of their disposable incomes in transportation and commuting expenses because of the remoteness of the vast reservation.

The major industries on the reservation are government, construction, utility companies, retail trade and mining. Overall, the Navajo economy is heavily dependent on the public sector. The degree of Navajo economic self-sufficiency remains extremely low. The major cause of the underdeveloped Navajo economy can be attributed to:

(1) The continual leakage of Navajo dollars flowing off reservation in commercial trade and services.
(2) Lack of a solid private sector and industrial economic base.
(3) Lack of Navajo financial development resources.
(4) Lack of technical and professional expertise.
(5) Lack of control over the Navajo mineral resources.
(6) Excessive government rules and regulations.
(7) Lack of a coherent land use base for development purposes.
(8) Unfulfilled federal commitment on economic and social development.

Until recently, the Navajo Nation solely relied on the royalties received from the mineral leases to support the Tribal government. However, this revenue base is unrealistic compared to the actual needs to developing a self-sustaining economy for the Navajo people. Tribal leaders also recognize that our minerals are a depletable resource. Therefore alternative strategies must be developed to diversify the Navajo revenue base.

ECONOMIC DEVELOPMENT GOALS

It was never the desire of the Navajo people to become a welfare society. There exists an inherent desire to once again become self-sufficient. In this regard, a long-term goal of the Navajo Nation has been established to develop a viable economy affording the maximum opportunity for choice of lifestyle and minimizing the dependency on the federal government. Chairman Zah and Vice Chairman Begay's strategy to accomplish this endeavor included:

(1) Designation of education for our people as the number one priority.
(2) Pursuing the decentralization of government which would allow for the people at the grassroots level to become directly involved in the planning, control and regulating of the development of their local communities.
(3) Re-negotiation of mineral leases and rights-of-ways which would provide more equitable and fair returns to the Tribe.
(4) Establishment of a solid tax base which would replace the overriding dependency on mineral revenues to support tribal government.
(5) Establishment of a permanent trust fund that would insure revenues for future Navajo generations.
(6) The exercise of Navajo sovereignty through the development of specific codes; The Navajo Nation Water Code, The Navajo Nation Tax Commission Code, The Navajo Corporation Code, the Navajo Uniform Commercial Code.
(7) The streamlining of the Business regulatory process which would encourage private sector development on a larger scale.
(8) Development of a solid financial base through the establishment of financial institutions and investments on the reservation.
(9) Establishment of a sound industrial policy which will guide and encourage industrial development opportunities through available natural resources.

BEST COPY AVAILABLE

(10) Assuming more ownership and management control over major industrial activity on the reservation.

Major accomplishments have been made in these areas already including the renegotiation of the mineral leases, imposing Tribal taxes which are now generating significant revenues for the Tribes and the establishment of a permanent trust fund. By the end of this fiscal year, the business environment on the reservation will be enhanced through the Corporation and Uniform Commercial Codes, a more cohesive and streamlined business regulatory structure, and a financial institution.

In conclusion, it is imperative to recognize that the tremendous strides in developing and enhancing the Navajo economy, through planning and generating millions of dollars from Navajo initiatives, is unrealistic compared to the billions of dollars needed to address the massive development needs of the reservation; housing, roads, public service needs, infrastructure needs, education, etc. Our goal for economic prosperity and plentiful jobs for our people can only be accomplished through federal recognition of our overall needs and continued support through financial commitments, rather than decreasing the federal programs that now provide some economic support. These same programs must be solidified through long term federal commitment. The philosophy of maximizing financial investments through the leveraging of dollars is a successful approach in developing significant economic development projects on the Navajo Nation and must continue if we are to succeed in reaching our socio-economic goals. The available federal development funding currently comes from EDA, MBDA/SBA, BIA, HUD-CBDG, DOL and ANA.

We must continually emphasize that a well-developed economy is an effective preventive measure against rampant breeding of social problems, whether these are children, adults or family in nature.

Thank you for your attention.

STATEMENT OF BENNIE COHOE, EXECUTIVE DIRECTOR, RAMAH NAVAJO SCHOOL BOARD, INC., PINE HILL, NM

Mr. COHOE. Mr. Chairman, members of the committee staff, my name is Bennie Cohoe. I'm the executive director of the Ramah Navajo School Board. I am a descendant of the Two-Came-to-the-Water Clan on my mother's side and the Green Meadow Clan from my father's side. I mention my clans because it has a very important role in a Navajo family. I think that there was mention here several times this morning that Indians need to know who they are, who they represent, where they are going, and the purpose that they were put on this Earth for.

So this morning I would like to commend the legislative staff of the Congress Select Committee for arranging a hearing out here in the Southwest, which we welcome. And I only regret that you don't have enough time to spend with us. I know you have taken time out of your busy schedule in Washington to be out here. But I was told that you would come out to my community at Pine Hill, in the Ramah area. I think that if you had an onsite visit that we were trying to work on previously with the House people, that it would enlighten you more in depth what a community can do. I think that since there has been so much focus on different views presented to you this morning, I think that what I will try to do this morning is to give you another view, which would be a community-based organizational view.

You have the State, you have a community, tribal-affiliated type of organization testimony, you have the tribal testimony. And mine is going to be a lower echelon, community-based type of presentation.

The Ramah Navajo community is located 85 miles southeast of Window Rock, and the Ramah Navajo community is geographically separated from the main reservation. We are known as a satellite

BEST COPY AVAILABLE

community of the Navajo Nation. There are three of us. Ramah is one.

We have approximately 2,000 tribal members enrolled at the Ramah Navajo Agency in the Ramah Navajo community. We function as a subgovernment of the Navajo Nation, as a tribal chapter.

The Ramah Navajo School Board was established by the Ramah Navajo Chapter in February 1970. That was when we started. I will try to give you a real brief view of what was there before 1970 and what we have done since 1970, through 1985.

I think that the reason for the move that the Ramah Navajo community took in 1970, it was more or less like the last straw. If we didn't make any move, we more or less would have been extinct or terminated or have gone out of existence, because prior to all that there had been numerous appeals to the Federal agencies, to the tribal government, to the State for numerous years, saying, "This is what we need, this is what we lack, please help us." And we waited patiently.

It was at a point when the only public school that was available to them in the community was closed. So we finally said, "What else can happen?" We were 90 percent uneducated, and the school closed. What else could happen? So it was then that we formed the Ramah Navajo School Board, Inc. And since then we got authorization from the agency that we were working with to pursue our own determination before the passage of the Indian self-determination law, back in 1975.

But when the initial planning started, they were looking at establishing educational services for the Ramah Navajo community. But then, as time wore on, they also lacked health services. And one of the other important things that they lacked was an economic base, which we are still struggling with today.

We have established a very comprehensive community-based, community-controlled education service center. We are servicing Head Start through the 12th grade. We have a student enrollment of about 500 students at Pine Hill.

We have since then, through the inception of self-determination, we have also incorporated by contract with the Federal Government to assume the responsibility of providing higher educational scholarship funds, employment programs, as well as human service programs.

Things looked bright for our future for a while. Things were taking hold, things were happening up until recently, when funds started to level off and pretty soon were frozen. Now all we're hearing is a percentage of this year, a percentage will be taken off next year. So we're going back the other way.

And I think that when that is happening, people fail to take note that there was some accomplishment that was made in our community now that is not being recognized, and that if the support and the funding were maintained for just a few more years, I think that a true self-sufficiency, as well as a true self-determination accomplishment, would have been obtained in the Ramah Navajo community.

So I think one of the challenges that I pose to the committee today is, if Washington and the Congress want to reduce or cut off funding to Indian social and economic programs, then I think that

you then have to first put in place, I guess, from community involvement on up to the tribe and the Federal Government involvement, and make sure that the community knows what's going on before anybody can bring in a plan and say, "Look, this is what we have now, but this is all the documents that come with it, what we want to give you."

So every Federal dollar that we receive, there's usually about 2- or 3-inch-thick documents that say, "OK, before you get this money, this is what you have to sign."

In that what we see is layers and layers of redtape which dictate how we're supposed to account for each penny. We don't oppose being accountable to the Federal Government, but the thing is that it is time consuming when you have to dot every I and cross every T and you have to put another number or another letter in each block that is presented to you. But then again, you just sit there month after month, filling that out and trying to make somebody aware, hopefully in Washington—and as I go to hearings in Washington, Congress is still not fully aware of what is really happening in the isolated communities.

So where does all the mass of paper that we prepare and send to the Federal Government go? Who uses it? So that's the problem. We are overregulated. We are still looked upon as if we are semiinstitutional.

As mentioned earlier, it's like being back in Fort Sumner from 1864 to 1868. We have not been totally released from that today. We still have to check out and check in every time we leave the reservation. It's ridiculous, and I don't think that we can afford to live like that or continue that in the future, and we should be released from being a burden to the Federal Government today. We have done——

Chairman MILLER. Mr. Cohoe, I'm going to have to give you about 3 more minutes. I want to make sure that we get through all the witnesses and still have time for questions.

Mr. COHOE. OK. We have done many major, I guess, planning. And now this is just on hold, you know, what pertains to educational programs, economic development, and so forth.

So what we need to do now, you know, is if we could be allowed to work jointly and cooperatively with the Federal agencies that need to be aware of the plans. And what we ask from Washington is that when they are submitted and presented in Washington, that they also be appropriately funded and that we have continued support and that the plans that we have worked on at our level be funded until we can become self-sustaining, until we can become self-sufficient.

So I would like to conclude my statement because I know there is a time constraint on us. So if there are any questions, I will answer questions.

I would also like to request that the hearing record for the Ramah Navajo community remain open for another 2 weeks, because we are still working on a more detailed document with more statistics that will be forthcoming within the next week. We will send that directly to Washington. Thank you.

[Prepared statement of Bennie Cohoe follows:]

PREPARED STATEMENT OF BENNIE COHOE, EXECUTIVE DIRECTOR, RAMAH NAVAJO SCHOOL BOARD, INC., CPO DRAWER A, PINE HILL, NM

Mr. Chairman, Members of the Committee, and Committee Staff:

My name is Bennie Cohoe, Executive Director of the Ramah Navajo School Board, Inc. I am descended from the Two-Came-to-the-Water Clan on my mother's side and from the Green Meadow Clan on my father's side. I mention my clans with pride, because they represent the important place of the Family in the life of our People.

It is my pleasure to address your Committee today and to share with you our accomplishments on behalf of Children, Youth, and Families, as well as our concerns and recommendations.

The Ramah Navajo School Board, Inc., is an independent, community-governed human services organization serving the People of the Ramah Navajo Community. It was established nearly sixteen years ago, at a time when we saw that educational and other services for our People were not adequate—and our community decided to take matters into its own hands by establishing a local, community-controlled school. We were the first American Indian community to establish its own school facility and program from scratch. And when the Indian Self-Determination and Education Assistance Act of 1975 was passed as Public Law 93-638, we were among the first Indian organizations to contract with Federal agencies for the execution of programs in service to our People.

We were also the first American Indian community to construct and contract for the operation of a community health clinic. We were the first to establish an Indian community-based, FCC-licensed radio station. There are other areas, too, in which we have broken new ground in the work of Indian Self-Determination. Various Federal grants have enabled us to experiment with new ideas and alternatives—sometimes to fail in the trying—as well as to model and demonstrate effective educational and community development approaches.

So we do have some accomplishments we can point to and build on. Our school facility, although it has not been completed, is a beautiful one, and we continue to build an educational program that is responsive to the needs and strengths of our children. There are about 500 children in our various educational programs, and several hundred adults in our adult education and vocational offerings. We provide a wide range of educational and community services as part of our comprehensive approach to community development, including a highly successful Housing Improvement Program, a locally-contracted Social Services Program, an innovative Rural Technology vocational program, a locally-contracted health services program, a community-based Youth Group Home facility, an Adult Basic Education Program, a JTPA Manpower Program, and our own Facility Management Program. We also have a lot of experience in developing, certifying, and managing administrative systems that somehow keep us accountable and responsive to the dozens of Federal and tribal agencies and their regulations that we have to work with.

In the process of working on all of these things, we have found a few things that really do work. For example, our community-based Youth Group Home really does involve local families and encourages family reintegration. Our Rural Technology Program was based on the strengths and needs of the community, as well as the economic realities of Western New Mexico, and is being looked upon by Tribes around the country as an example of "appropriate development." Our school program is responsive to cultural and linguistic differences, and results are starting to really show up. Our Housing Improvement Program has brought new or improved housing to dozens of community families, thereby reducing various kinds of stress caused by inadequate shelter.

I say these things to you not to boast, but to give you a sense of the edge-cutting work we've been involved in, so that you'll know that our concerns and recommendations are based on that kind of experience.

We will be presenting your committee with detailed written material describing our programs and presenting the various issues we face, backed up by statistics and supportive information. For now, I want to highlight the big issues affecting our development.

There are three issues that I want you to remember from our testimony: Economy; Alcohol; and Local Initiative.

The time has come for major breakthroughs in economic development for Indian communities. This is the "bottom line" of what we're facing. Lack of a true, viable economy is the most powerful cause of underdevelopment and family breakdown. It is this issue which most seriously impacts our children, youth, and families. If Congress wants to be relieved of the burden of financing social programs in Indian communities, then it needs to support true economic development. By true economic de-

BEST COPY AVAILABLE

velopment, I mean working toward the sort of economy that has roots in the community, that can be sustained and governed by the community, that utilizes the unique strengths and potentials of the people of the community, that involves the people in their own development, that results in eliminating the need for welfare, that rebuilds the family and gives hope to our children and youth, that creates and circulates wealth within the community.

For the past decade-and-a-half, we have been developing the only real resource we have: our People. We think we've done pretty well in that span of time, although there is much more we need to do. But we're finding that "there's no place to go." It is very hard to motivate our young people to excel in school, when they see nothing around them to invest their skills in. Simply put: there are no jobs. There is no genuine local economy. Despite millions of dollars in Federal programs on Indian Reservations, our unemployment rate has stayed pretty much the same: in the 60% to 70% range. There is nowhere else in this country but on Indian Reservations that you see these kinds of statistics year after year.

We know that some people are tempted to put the blame squarely on the shoulders of the Indian community itself. But that is so unfair that it almost doesn't deserve attention. However, these are hard times, and the demands on the Federal budget are throwing a scare into Indian Country. It is important that Congress understand that there is a genuine desire in many of our communities to be independent of the Federal dollar, and that we are ready to take charge of our own development. But some major obstacles need to be overcome before the opportunity is really there; the most important factors are: access to capital; sustained support for medium- and long-range efforts, meaning five- to ten-year programs of development; and red tape.

Our second issue concerns one of the most disastrous results of our economic underdevelopment: alcohol abuse. The great majority of crimes, child- and spouse-abuse cases, accidental death cases, and mental health-related problems in our community come from this one activity.

Our Health Center notes that the health profile of our people is beginning to look more and more like the profile of general American society. We seem to be getting serious infectious diseases and infant mortality under control. However, we are starting to see more and more health problems related to mental and family stress. As economic stress hits the nation in general, communities like ours feel the affects many times over—and the hopelessness the people feel leads to these mental health problems.

Our third issue concerns problems we are having with the implementation of Self-Determination. For sure, some good things have happened as a result of the partnership of the Federal Government and Indian Communities. The Ramah Navajo School Board could not have accomplished what it has without the support of Federal agencies that have been trying to help us resolve our problems and work toward our dreams. However, there are some problems in carrying out both the spirit and letter of Self-Determination. In general and clear terms, we are heavily burdened and distracted by "the bureaucracy". Our administrators constantly complain that they have little time and energy left for the "really important things" after they've wrestled with changing regulations, bureaucratic requirements, and inter-agency conflicts. One way to explain is to say that we identified that we wanted to get from Point A to Point B, but we lacked the means to get there. So the government listened to our plans and decided to provide us with a vehicle that would get us there. That was all fine and good. But then, before delivery, the type of vehicle was changed, the maps were changed to make us go through all sorts of side roads and checkpoints on our way to Point B, and over time, the vehicle was loaded down with all kinds of things, slowing our pace and frustrating our progress. I think that you would have a hard time believing how many sets of regulations, procedures, requirements, and deadlines we have to deal with—and how complicated it is just to keep afloat. We're managing, but there's got to be a better way.

In summary, we would like to make the following recommendations:

1. Make economic development the number one priority with regard to Indian communities.

2. Eliminate a lot of the red tape involved in getting small businesses started. Ensure that Federal agencies work in partnership with the local communities, encouraging new solutions, rather than placing so many stepping stones in the way. Encourage local planning and control.

3. Limited one-year projects are totally insufficient and often self-defeating. The development process takes time. Put a priority on supporting 5- and 10-year Development Plans. Such plans should be approved and funded by a special agency of the government, with built-in technical assistance over the entire span of the project.

BEST COPY AVAILABLE

Lead agencies should assist tribal communities in developing coordinated funding packages, utilizing funds from a variety of sources, both Federal and non-Federal. Small communities such as ours must be directly eligible for these long-term projects, without having to go through the larger Navajo Tribe.

4. Encourage the development of economies appropriate to the individual communities concerned. Plans should be supported that call for developments which can be sustained locally in the long-run and which involve more and more of the local people.

5. Free up capital, seed money, and financing for local enterprise development, such as a revolving loan fund. Recognize the difficulty of finding "matching funds" for development projects, and provide enough capital to get things going.

6. Encourage tribal land consolidation and other alternatives which will make it easier for Indian communities to carry forward significant development.

7. Recognize that political organizations are not always the best channels for development. The experience of the Ramah Navajo School Board has shown that an independent, professional organization can often operate more effectively and with better result than political ones.

8. Shift significant funding toward preventive health services, especially mental health and alcohol-abuse-related concerns.

9. Support programs which foster Youth Leadership and which provide for experiences which are challenging and which build confidence and self-reliance.

10. Get back to the spirit of Self-Determination under PL 93-638. Eliminate unnecessary bureaucratic levels and regulations. Localize control over the processes of management. Free up local administrations to really push forward on new initiatives and accomplishments.

In closing, I would like to thank the Committee for this opportunity to share with you our experiences and recommendations. Please keep our testimony open for the inclusion of forthcoming written documents which will provide more specific statistical and supportive information.

Thank you.

Chairman MILLER. Thank you. And I should have said at the outset that the hearing record of this last week will remain open for a period of 2 weeks. So if there are people in the audience that want to comment or send the committee their remarks and have them made part of the permanent record of this hearing, feel free to do so.

For those of you who want to simply comment on something that you have heard here and don't really care whether it's part of the record, you obviously have a longer time, because this is not a subject that we are going to simply abandon after that 2-week period of time. That clearly goes for all of the witnesses, who again may have heard something that they may wish to supplement. This record will be open for formal purposes for 2 weeks.

Ms. Bronson.

STATEMENT OF MELINDA BRONSON, DIRECTOR, TRIBAL SOCIAL SERVICES, UTE MOUNTAIN TRIBE, TOWAOC, CO

Ms. BRONSON. Good morning. My name is Melinda Bronson. I am the social services director for the Ute Mountain Tribe in Towaoc, CO.

I'm very glad that Mr. Lehman brought up the question of what makes the Indian communities different from other communities across the country who are faced with issues of poverty, because that is one of the issues I'm going to address.

I think family fragmentation is something that is fairly unique to Indian reservations. You may see a lot of poverty in Appalachia, but I think the family is more intact in those communities.

I have been the social services director for the tribe for the last 6 years, and I have never restricted my activities to administration. I

BEST COPY AVAILABLE

have always carried a child welfare caseload. I have been in the field daily, so that I have been dealing directly with children and their families on a daily basis. I hope to acquaint you this morning with some of the very serious problems related to family dysfunction and foster care on the reservation at Towaoc and to share with you some of the ideas that the Ute Mountain people have to positively impact these problems.

Towaoc is located in the southwest corner of Colorado. It is a boundaried, isolated reservation 13 miles from Cortez, the nearest town. There about 1,575 people on the reservation, and right now we have 70 children in foster care. That means that 1 out of every 22 people on the reservation is in 1 out-of-home placement. In contrast, Montezuma County, the county in which we are located, has 17,600 people, with 20 children in placement. That breaks down to 1 out of every 880 people.

Looking at the figures in another way, this means that the reservation has 40 times the number of children in foster care than the neighboring non-Indian community. The staggering difference in placements is not due to different criteria for placement.

We have a foster care review board. People from the county staff sit on that review board and review every single placement we make. In the 2½ years that board has been functioning, our counterparts from the county have never found a placement to be unnecessary.

The reasons for the extremely high placement rate are longstanding and they are complex, but they are understood by the Ute Mountain people. The tribe's officials and staff understand that when the majority of an entire population of children was forced into boarding schools and there they spent all the years when they would have normally developed the skills related to family life, that an extremely high number of parents emerged without the skills they needed to parent their own children.

We also understand the appalling 1980 census data which revealed that, for our census tract, 69 percent of the people who were 18 years of age and over do not have a high school diploma. For the age group 25 years of age and older, 83 percent of the people in our census tract do not have a high school diploma.

This year I wrote a CDP proposal for funding to help keep youth in school. In doing the research for the proposal, I learned that the dropout rate for non-Indians in Montezuma County is 9 percent. And that's high for Colorado, because the State dropout rate is around 6 percent. But the dropout rate for Indian students this year is 23 percent. And the tribe understands the implications of these figures for family dysfunction and the risks that they imply for foster care.

Today about 90 percent of foster home placements on the reservation are made at least superficially because of alcohol abuse on the part of parents.

In 1974 I did a year-long research project in Riverside County, CA, for my master's thesis. The project was to determine the reasons that children were going into foster care, and clearly, the immediate primary cause there was alcohol abuse on the part of parents. That was primarily a non-Indian county.

The children who were going into foster care were from census tracts which reflected very low mean annual incomes, a high number of single heads of households, strikingly low numbers of years of education completed, and the high per capita consumption of alcohol which accompanies what we called in the sixties, the culture of poverty.

That data was collected 12 years ago in a different place, but the people of Towaoc understand today the same cycle of lack of education, unemployment, financial stress, hopelessness, depression, and alcohol abuse which relates to the extremely high rate of foster care on the reservation.

The costs are enormous. Putting aside the costs in human resources, I would like the committee members to understand that it costs $2,000 a month to keep one child in a residential child care facility, which is the facility that we use when foster care fails, and it fails often.

At that rate, we are spending $24,000 a year per child, and a small program like ours could spend $480,000 per year or $2,400,000 over a period of 5 years just to try to rehabilitate 20 children.

The people of Towaoc do not need any more feasibility studies. We don't need any more research projects and we don't need anymore needs assessments. We have very good ideas about the preventive projects which could impact these problems and interrupt the cycle of foster care. What we need are the resources to fund and staff projects that will give mothers and fathers the tools to parent their own children.

If funding is not made available for preventive projects, there really isn't any reason to expect that the trends in foster care are going to be reversed. We now have a knowledge base which will enable us to impact these trends, and there isn't any justification any longer for the enormous costs of attempting to patch up well-established problems after the fact with ineffective approaches.

Some of the specific recommendations we have involve the way social services administration money is spent. It is really pretty arbitrary. The BIA needs to take the social services administration funding out of the band and allocate it according to need, based on caseload size, based on the kinds of needs that are demonstrated in Indian communities.

There is not one nickel of this child welfare assistance money that is being used for prevention. It is all being used for foster care. There are some initiatives going on in Washington right now through the BIA to try to reallocate some of that money for preventive projects, but the issue needs a great deal of support.

Chairman MILLER. Are you talking about Indian Child Welfare?

Ms. BRONSON. I'm talking about child welfare through the Bureau of Indian Affairs. I'm going to spend in excess of $600,000 this year for 70 children to try to maintain them in foster care and in residential child care facilities. I am not committed to the Foster Care Program. I have tried, I have written proposals, I have written memos, I have done everything I could think of to try to get money to use for preventive measures, because there have been research and demonstration projects funded through HDS and CDP proposals for years. We know what will work. We really do have

the information about what will reverse some of these problems. But year after year our funding has been earmarked to take care of these problems after the fact.

[Prepared statement of Melinda Bronson follows:]

PREPARED STATEMENT OF MELINDA BRONSON, MSW, ACSW, DIRECTOR, TRIBAL SOCIAL SERVICES, UTE MOUNTAIN UTE TRIBE, TOWAOC, CO

The focus of the testimony involves foster care and family dysfunction.

As Social Services Director for the Ute Mountain Tribe for the last six years, I have not restricted my activities to administration. I have consistantly maintained a child welfare caseload, so that I have been in the field dealing directly with children and their families on a daily basis. In the next five minutes, I hope to acquaint you with some of the very serious problems related to family dysfunction and foster care on the Reservation at Towaoc and to share with you some ideas the Ute people have about how to impact these problems in a positive way.

Towaoc is located in the southwest corner of Colorado. It is an isolated, boundried Reservation thirteen miles from Cortez, the nearest town. There are about 1,575 people on the Reservation. Our department currently has 70 children in foster care. This means that one of every 22 people in Towaoc is in out-of-home placement. In contrast, Montezuma County, the county in which the Reservation is located, has a population of 17,600, with only 20 children in foster care. This translates to only one placement for every 880 people. Looking at these figures in another way, the Reservation has 40 times the number of children in out-of-home care than the neighboring non-Indian community. This staggering difference in foster care placements is not due to different criteria for placement between the Tribe and the County Social Services Departments. County staff people regularly attend our foster care review board meetings which are held to determine the appropriateness of each placement. In the 2½ years the board has functioned, the members have never found a placement to be unnecessary.

The reasons for the extremely high placement rate are long standing and complex, but they are understood by the Ute Mountain people. The Tribe's officials and staff understand that when the majority of an entire generation of children were forced to spend all of the years when they would normally have developed the skills related to family life in boarding schools, an extremely high number of parents emerged without the tools needed to parent their own children.

Also understood is the appalling 1980 census data which revealed that for the Tribe's census tract, 69% of the people age 18 years of age and over had not completed high school. For persons 25 yeaers old and older, 83% had not finished high school. This year I wrote a CDP proposal for funding to help keep youth in school. In doing research for the proposal I learned that the dropout rate for non-Indians in Montezuma County averages 9 percent. This is high for Colorado, where the state average is around 6 percent, but the rate for Indian students in the same county is 23 percent. The Tribe understands the implications of these figures for family dysfunction and the risks they imply for foster care placements.

Today about 90 percent of foster home placements on the Reservation are made, at least superficially, because of the alcohol abuse on the part of the child's parents. In 1974, I did a year long research project in Riverside County, California for my Master's essay. The project was to determine the causes underlying foster home placements there. Clearly an immediate primary cause was alcohol abuse on the part of parents. The children who went into foster care were from census tracts which reflected very low mean annual incomes, a high number of single heads of households, strikingly low mean years of education completed, and the high per capita consumption of alcohol which accompanies what we called in the 60's "the culture of poverty." That data was collected 12 years ago in a different place, but the people of Towaoc understand today the same cycle of lack of education, unemployment, financial stress, hopelessness, depression, and alcohol abuse which relates to the extremely high rate of foster care on the Reservation.

The costs are enormous. Putting aside the costs in human resources, the committee members should understand that the cost of keeping one child in a residential child care facility in Colorado is around $2,000 per month or $24,000 per year per child. At that rate, a small program like ours could spend $480,000 per year or $2,400,000 over a period of five years to attempt to rehabilitate 20 kids in RCCFs after foster care has failed. Foster care, incidentally, frequently fails to be the answer to the problems of children who need alternative care.

BEST COPY AVAILABLE

The people of Towaoc do not need any more feasibility studies. We do not need any more research projects. We cannot use any more needs assessments. We understand the problems facing children and their families at Ute Mountain. We also have very good ideas about those preventative projects which would impact these problems and interrupt the cycle of foster care. What we do need are the resources to fund and staff projects which will give mothers and fathers the tools to parent their own children.

If funding is not made available for preventative projects, there is no reason to expect that the trends in foster care will be reversed, and since we now have a knowledge base which will enable us to impact these trends there is no longer any justification for the enormous costs of attempting to patch up well established problems, after the fact, with ineffective approaches.

Chairman MILLER. Thank you. Let me ask you a couple of questions, and then we'll probably follow up with you in correspondence or on the phone. What is the source of the $600,000 you are spending for foster care maintenance?

Ms. BRONSON. The Bureau of Indian Affairs.

Chairman MILLER. And they get that from the Indian Child Welfare Act?

It is part of what the BIA does with its funds?

Ms. BRONSON. Right.

Chairman MILLER. If you place children in out-of-home placement, do you get any State funding?

Ms. BRONSON. Oh, yes.

Chairman MILLER. But they have to be in a licensed facility?

Ms. BRONSON. We license them.

Chairman MILLER. You now license your own facilities?

Ms. BRONSON. Our tribe initiated a State-tribal agreement with the State of Colorado. We were one of the first tribes to do that. Under our agreement, the tribe maintains custody of the children. My department licenses the foster homes, and for any child who is eligible for title XX AFDC Foster Care Funding, we are reimbursed from the State.

Chairman MILLER. So a tribal determination is all that you need?

Ms. BRONSON. Yes.

Chairman MILLER. And so again you can license a home and you can place a child, and funding will follow?

Ms. BRONSON. Yes; if the child is eligible for AFDC-FC.

Chairman MILLER. Again, I'm trying to look at the range of this, because in some States that's not the case. In some States, the State won't even talk to the tribes about State-tribal agreements. How many caseworkers do you have?

Ms. BRONSON. Right now I only have five, and all we're doing is crisis intervention. Those children who are in foster care do not reflect our total caseload. We're working with over 320 children, trying to maintain them in their own families.

Chairman MILLER. But all of your money is for maintenance, not for services, not for preplacement services or unification services with families?

Ms. BRONSON. I applied for and received a title IV-B grant, a small amount of money that is being used for reunification. I think we have exhausted all of the resources that were submitted to us this year. As I said, I have also submitted a CDP proposal.

Chairman MILLER. Well, let me ask you a broad question. I would like to have other people respond to as well. I think there is general agreement that there are just inadequate resources to meet the

BEST COPY AVAILABLE

demands that are being placed upon the social service sector and, in some cases, the physical development of the reservations. But there is also a very strong suggestion, and Mr. Cohoe made it the central theme of his statement, that the organization and the flow of money from Washington is just inconsistent with the rational management of that money at the tribal level.

And we heard—a whole series of anecdotal stories that stand out over this week to support this notion. But we visited with a young woman from the Navajo village of Paiute, up on the Navajo Reservation, who had 8 members or 10 members of her family in a one-room house or one-and-one-half-room house, living there. And she obviously wanted to move into the new HUD housing, but was told by HUD that they couldn't move in there because there were only three bedrooms. And under HUD regulations, it was too small, so she would have to stay in the one-bedroom house. The logic was lost immediately on everybody, but apparently it was not lost on HUD. And the stories just go on and on from this week.

And there is a strong suggestion that there has got to be, a full recognition that these are, in fact, local governments, that these are tribal governments, and funding has got to flow in much the same fashion that it does to other entities.

There are also some changes that have got to be made to respect the individual identities and problems of the tribes. What I'm trying to get to is the notion of whether or not—I sit on the Interior Committee, and it has the ability to legislate, something that the select committee does not—whether or not there should be a follow-on hearing, with the question being, "How do you reorganize Federal funding to make it more efficient and more usable at the local level?"

Obviously that is a very broad question, and it cuts through the highway moneys and, as we have heard, Indian Health Service moneys, social service moneys, across the entire board. But at a time when there is not a great deal of likelihood that the Federal Government is going to increase funding, at least it seems to me that we ought to be able to get as much out of the turnip as we can when we're squeezing it.

Yesterday we were told that Gila River had contracted for their entire social service work on the reservation. But the Bureau of Indian Affairs determined that, therefore, they would have an excess person who had nothing to do, so they wrote that person in at $35,000 a year to administer the contract.

We don't administer military contracts. The whole contract was only $2,000,000. But they had to absorb the cost of a BIA person who said, "Wait a minute, I'm not going to have anything to do this year."

And so there seems to be a craziness around the flows and the obligations that simply don't work in the Indian nations. Do you want to respond to that issue? I think we're going to have a second round on this issue, because it does come forward out of these hearings.

Ms. BRONSON. I think a second round would be extremely helpful. I think that there are a lot of people who have some very good ideas about reorganization of the way the funding is done.

Just to give you an example, several months ago I got a telephone call from the BIA Area Office in Albuquerque. They advised me that they had come up with about $2,500 for me in training funds, administrative money for training funds.

And I thought, "Great. We can put on a training session in Head Start with Head Start children and talk to those kids about alcohol and talk to those kids about how to feel good about themselves and how to develop a little self-esteem and so forth."

And the Bureau said, "No, that money has to be used to train social workers in child welfare."

Well, I've got a very well-trained staff. We've got more master-degreed people in social work in that area of Colorado than in a lot of places, and these people have worked in social services there, some of them, 8 to 12 years, and we go to training sessions that are put on quite regularly.

We were literally forced to use that money to put on another training session for social workers and professional people or we would have lost it, so we did. But those are the kinds of things that happen all the time. I think your idea is a very good one, and I think there would be a lot of interest in another hearing.

Chairman MILLER. Thank you.

Ms. BRONSON. Thank you.

Chairman MILLER. Does anybody else want to respond to that notion? Mr. Lehman.

Mr. LEHMAN. Mr. Chairman, the young lady was talking about the dropout rate, and I think there is a uniqueness there. The highest dropout rate we have in south Florida is among the 16- and 17-year-old Cuban people. They drop out of high school, boys and girls, to take jobs as busboys or take jobs as stockboys or fast food workers, and they earn supplemental income for their families. They don't drop out and hang out, they drop out and get jobs.

And that is a problem I think with your dropouts. They have no place to go. Is it basically an agricultural economy on most of these reservations?

Ms. BRONSON. The Ute Mountain people have always been a hunting community, and they are really not involved in agriculture.

Mr. LEHMAN. But there are agriculture-based reservations?

Ms. BRONSON. Oh, yes.

Mr. LEHMAN. And do they have cash crops?

Ms. BRONSON. Yes.

Mr. LEHMAN. And do they get all the benefits from the Department of Agriculture that the rest of the farmers are getting?

Ms. BRONSON. I don't know.

A VOICE. They're not farming anymore.

Ms. BRONSON. I don't think there are very many Indian people that are producing any significant kinds of agricultural products.

Mr. LEHMAN. I hear from farmers in Colorado that they are affected by the corn raised on Indian reservations under cost and shipped to Colorado. Now I'm just hearing these things.

Chairman MILLER. They must be the worst farmers in America if they're impacted by that problem.

Ms. BRONSON. I'm not aware of that, but you're quite right. The school dropouts on the reservation really do not have any place to go.

Mr. LEHMAN. The lady over there was talking about the 60,000 graduates. How many graduates do you have?

Ms. REYNA. I would like to correct the statement I made. We have 60,000 high school students in our reservation schools, and of those 60,000, there are 10,000 that graduate on an annual basis, an average of 10,000.

Mr. LEHMAN. Where the money is, is in the Department of Defense, in our Voluntary Army. Are any of these young people going into the Volunteer Army?

Ms. REYNA. Some are, yes.

Mr. LEHMAN. They are making careers out of the military? Are any of them going to the service academies?

Ms. REYNA. Very few, very few; some are.

Mr. LEHMAN. How about those that have survived World War II or the other wars since then? Are they able to get medical support systems through the VA hospitals? Is that a problem? I know it's a problem in south Florida.

Ms. REYNA. The problem with the Veterans Administration—there is a real problem with veterans' benefits that come through the Indian tribes. There seems to be some kind of a breakdown in that program. As a result, the Indians, our Navajo veterans, do not get the benefits that off-reservation veterans get, due to the problems in that area.

Chairman MILLER. What is the size of your veteran population? You have a rather large veteran population?

Ms. REYNA. I don't know it, but I can find out.

Mr. LEHMAN. If you could get us some information on that. I remember in World War I, in the military intelligence, the only code that the Germans couldn't break was when there was a Navajo on each end of the communication and they would send messages through the Navajo language, and there was no way that the Germans could break that code.

Chairman MILLER. Mr. Wheat.

Mr. WHEAT. Did you say that 10,000 people a year graduate from high school?

Ms. REYNA. Yes.

Mr. WHEAT. What is the population on the reservation?

Ms. REYNA. About 162,000.

Mr. WHEAT. What is the average age?

Ms. REYNA. 19.

Mr. WHEAT. On the reservation, the average age is 19? What is the percentage of unemployment that you indicated?

Ms. REYNA. 32.7, average, on the reservation.

Mr. WHEAT. What really do young people have to look forward to upon graduation from high school? Is there a big difference in life on the reservation if you have graduated from high school as opposed to if you have not?

Ms. REYNA. The problem that faces all of our young people today when they graduate is, if they choose not to go on to college or training school, they don't have anything to do and they just go into a welfare style of life. Many of our young people are going on

to college, and that is because education is a top priority on our reservation. However, when they do finish college and they get a college degree, they can't come back to the reservation because there are no jobs to offer them.

Mr. WHEAT. What percentage of high school graduates do remain on the reservation, as opposed to people who leave?

Ms. REYNA. I would say about 85 percent.

Mr. WHEAT. Remain on the reservation?

Ms. REYNA. Yes.

Mr. WHEAT. When you look at the entire range of Federal moneys that flow into the reservation, do you have any clear idea of what percentage of them are devoted to economic development that might be creating jobs and opportunities for people to remain on the reservation?

Ms. REYNA. What percentage of the Federal money?

Mr. WHEAT. Approximately?

Ms. REYNA. The percentage of the Federal money going on to the reservation is minimal. I'd say probably around 5 percent, 10 percent, at the most.

Mr. WHEAT. If, as Chairman Miller suggests, there was some opportunity—and I don't know how it would be created, but I imagine there are people who do have ideas on it—if there was some way to be flexible with the funds that flow in from various agencies and to retarget those funds as might be necessary, would a choice be made, do you think, to dramatically increase the amount of money used for economic development, as opposed to money that is currently being used for crisis intervention?

Ms. REYNA. I don't think that I can answer that.

Mr. ESTEVAN. Mr. Chairman, could I say something?

Chairman MILLER. Sure.

Mr. ESTEVAN. One of the things that you're wanting to understand is what the flow is, as far as moneys coming down from the feds, down to the agencies. One of the things that we confront on a yearly basis is, you know, the BIA has what they call—we call it a Bible, and it seems like that's what they guide themselves with, the Bureau of Indian Affairs Manual. And from there, you know, it's a matter of interpretation to them, as well as to us. You know, we see it differently and they see it differently. And they're supposed to be overseeing the protection of the people and overseeing the moneys that should be spent in that direction, but it's not.

So, therefore, we're sort of held back in that sense. I think that was in the reorganization that was starting to be initiated a few years ago, but that didn't really work at the end. The Bureau interceded and took it as they saw it, saying, you know, that it was in the best interest of the Indian tribes.

That is one of the things that I think you need to understand, what happens when the money comes down through the channels and through the Bureau of Indian Affairs. And then the services, like this young lady that left, the moneys then are not fully implemented out in the field. There's overhead taken from that amount of money that is being allocated or appropriated from their end.

And another thing I think is, the question keeps coming up, you know, as far as what the child does on the reservation in its idle time or if they drop out. I think I alluded to that earlier, that a lot

of these youngsters do not have a good grasp of what the community's traditional way of life is and they really do not identify with that. But we are starting to make an impact on that so that they could be part of the community's way of life, meaning that they could be useful in a sense other than just recreation. We don't oppose recreation.

In that sense, it's very difficult, I think, from your standpoint to truly understand, you know, what is taking place in the community life. It's like Mr. Cohoe just mentioned. If you could come out and see it, you could start to see what we are talking about as far as trying to get that in place and at the same time deal with these programs that we have, because it's important that we continue to address the innovative things that have impacted on economic development.

Chairman MILLER. Governor Paytiamo.

Governor PAYTIAMO. I don't think there's no such word anymore as dropouts. I think there's more of like pushouts because of delinquency problems. The children need, you know, like I said a while ago, prevention, because there are not enough counselors in the school to provide counseling to those children and they're not encouraged to continue. As a result, they're pushed out. They're left out in the cold.

And when you talk about funding, I think that there should be direct funding to the tribes so they can cut out the middle man.

And speaking of manuals, if the tribes have a procedures manual, I think they should be allowed, provided that it is in line with the Federal guidelines, that I don't think the Indian tribes should be forced, where the Bureau of Indian Affairs says, "Well, this is the Bible and you have to live with this." I think that if a tribe has their own policies and procedures in place similar to the ones that they have, that they ought to be allowed to use their own procedures manual and not be dictated to by the BIA manual, which I understand does say that you need to put something in place at the local level.

And then also, you mentioned that you're on the Department of Transportation. I know that through ANA mechanisms there were some of these, because the various agencies at the Washington level, those of us at the local level, we have to argue with these people because we need to educate those agencies on how we operate at the local level or how to deal with the Indian people, because it's completely new compared to the cities and counties.

I think that there is, you know, the Bureau of Indian Affairs, the Indian Health Service and really the ANA understands the Indian situation. And then I think like the Department of Transportation and the integration programs and those programs that were funded for DOL were channeled through ANA because they know how to deal with the Indian people. And I think if that agency was in place, I think those funds could really get out to the tribes.

Mr. LEHMAN. If I could interrupt, if you have any problems with the Department of Transportation in relation to the way they deal with the American Association of Indian Affairs, let our office know. I think we can provide the kind of testimony at the hearings next year to clear some of that up.

We know that you have plenty of contact with Federal agencies. But the problem is that these Federal agencies raise expectations, and then nothing happens. And I think that creates frustration that escalates your problems.

Mr. ESTEVAN. You know, I would like to say a little bit more on the Department of Transportation. You know, we usually make an annual visit to the State agencies, and we like to go to the State Department of Transportation to see if we could borrow like DWI training kits or resuscitators, that kind of thing. And they always tell us, "I'm sorry, we can't help you with any of this equipment to loan to you. You have your Bureau of Indian Affairs and you have your PHS, and you should get your services from there. You can't get it from the State."

And one more item. I would like to end by saying that I'm glad that you guys are going up to Laguna/Acoma High School, and I would like to invite you to come out and see what we're like. Because as I indicated in my testimony, we are the oldest continual inhabitants in this whole Western Hemisphere. You know, Santa Fe wants to say that they're the oldest, but I think that we are. We've been in existence since 1200 A.D.

Chairman MILLER. Thank you. Mr. Solomon, let me commend you on your incredible effort on behalf of your son, Travis. But let me ask you, why are you still paying after the determination that these were related services under Public Law 94-142?

Mr. SOLOMON. I really wish I had an answer to that.

Chairman MILLER. Has there been an agreement with the school district for reimbursement of those services?

Mr. SOLOMON. No, there hasn't been an agreement made for reimbursement. Speaking for myself, it has been a slow step-by-step process of learning to attain what I have now. Thank you for posing that question, I will consider that information as part of the future Special Education Process steps to pursue.

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

FLOYD R. SOLOMON,
Education for Parents of Indian Children with Special Needs,
Bernalillo, NM.

DEAR MR. SOLOMON: In reviewing your statement in the transcript of the hearing on Native American Families held in Albuquerque on January 10, 1986, you mentioned that a determination had been made that certain essential services for your son were considered related services under P.L. 94-142. If you have any information on why you remain financially responsible for these services, when in fact the school system is responsible, we would appreciate having the opportunity to include that clarifying information in the hearing record.

Thank you for providing the Select Committee with this information .

Sincerely,

GEORGE MILLER, *Chairman.*

RESPONSE TO QUESTION POSED BY CHAIRMAN GEORGE MILLER

There are basically two parts in answering your questions, Mr. Chairman. The first part revolves around parent education regarding P.L. 94-142. The second part is regarding the school administrative interpretation of "related services" and "appropriate education."

In New Mexico there are limited parent education resources, particularly, in the Indian communities. At present I can name only one program, the EPICS Project, which I am currently affiliated with that provides Indian parents with that educa-

BEST COPY AVAILABLE

tional information. Many parents, both Indian and non-Indian, don't understand their rights and responsibilities granted under P.L. 94-142. Though their rights may have been communicated to them in writing or verbally, it's quite difficult to immediately apply those principles to the situation. Therefore, I depended very much on the administrators to act responsibily in identifying and providing for my child's educational needs.

As time progressed my interaction with parent organizations outside the reservations increased. Through this process, I became more aware of the implications of P.L. 94-142.

Having my son, Travis, attend both public and Bureau of Indian Affairs (BIA) schools in New Mexico, the administrators gave me the impression that they had their own definitions of "related services" and "appropriate education."

For instance, had I permitted my son to be admitted to the public school Special Education Department, I would have consented to mainstreaming as being placed in a side by side classroom with behaviorally disordered children for the entire day, eating lunch with non-handicapped children but at a separate table and recess would consist of Travis playing with his behaviorally disordered classmates on a remote section of the playground. Related services was accepting what the school was providing and in some cases, not providing.

At the BIA school where my son is currently enrolled, there is no one to provide an audio verbal program. The speech pathologist recently hired has little experience with hearing impaired children and is not state certified. The school administrator at the school is still trying tc decide if the audio verbal therapy is a related service, therefore has not yet contracted anyone to provide the service.

In the interest of maintaining my son's progress, I have and continue to pay for his therapeutic services.

Chairman MILLER. I am not looking for a definitive answer, but the reason I throw this out is I would like people to start thinking about it. Because I think what I would like to do is go back to the committee of original jurisdiction, certainly with respect to the BIA. I also sit on the Education Committee that does 94-142—it does a number of the other programs that the Indian education systems draw upon—and start to take a look at where there are hurdles that have been established for the Indians tribes to jump over that are meaningless. Again, if we are going to move down the road of self-determination, at some point we have to make a decision that the Indian tribes have the best interests of their children and families at heart, and should make the determination of how to move some of this funding around.

I have been one who generally has resisted block grants, as they have been suggested by the President of the United States, because he usually starts out by saying, "We're going to cut 25 percent of the money and then we're going to give you a block grant," and that never quite works out.

But I think the question of some consolidation within social services, within physical development, within some of these programs seems to me to make sense, especially at a time when we're going to go back with this new Gramm-Rudman procedure and we're going to spend an awful lot of time talking about cutting budgets.

So it would seem to me that we have the same obligation to see, if we are not going to allow budgets to grow, to see whether that money can't be used more efficiently.

One of the things we have been talking about is maybe later, at the end of next month or the beginning of the following month, in the Interior Committee, asking some of the Indian Nations to get together again to talk about this and make some recommendations, so that as we respond to those budget mandates, we will have some ability to make those dollars go further. And so I would just like to

94 BEST COPY AVAILABLE

throw this out for suggestion at this time and have you think about it. We'll obviously get back to you, as I say, through the interior committee, not through the select committee, and see if we can convene a meeting to hear what people have to say.

I have done this in some other areas, and I think it has worked out fairly well when we get to a point where there is an impasse on the logical use of money. And one of the things I would be interested in is, what is the total BIA allocation that the various tribes receive under different programs and for different purposes?

I think it's much more difficult when we get into education for the handicapped, when we get into the Department of Transportation, because they have a number of different missions. But the BIA, in theory, has one. But I'm afraid that they're chopping it up into such fine gradations that we're losing some of the money that should go into direct services.

I will not belabor the point. We do have to go to a site visit. Let me apologize to the sites that we haven't visited. We have had a dozen different site visits this week, and I'm sure that I will personally engage in others in the future. And they have been very, very helpful to the committee and to the staff in really understanding some of the environments of the reservations.

Yes, Mr. Solomon.

Mr. SOLOMON. I would like to mention that administrative decisions regarding the Indian Children's Program have impaired the services to a number of rural communities and caused confusion between agencies.

The Indian Children's Program served many rural communities by providing clinical diagnostic services. Its disbandment has left Government agencies wondering who will have the responsibility of providing services to the handicapped. Though I would agree that contracting diagnostic services would allow increased responsibility by the contracting agency and somewhat lessen the burden of Indian Health Services, there has been no plan of action devised to provide much needed services during the interim of the acquisition of responsibilities.

Chairman MILLER. But there is still an obligation for the payment of those related services under 94-142. I wrote 94-142, and I have been in battle with school districts ever since I did that. There is an obligation.

Again, for the Navajo Nation, we see that those funds flow to those handicapped kids in that school for the various related services that are necessary. That's an obligation of the public school system.

Mr. LEHMAN. Mr. Chairman, does WIC money go to the Indians?

Chairman MILLER. Yes, WIC money is one of the things that goes very well to the Indians.

Mr. Cohoe? Then we're going to wrap this up.

Mr. COHOE. Thank you. I just want to bring out one more thing here for the Department of Transportation. You know, there are many problems with the roads.

In my community of Ramah we have about 228,000 acres of checkerboard land for the Ramah Navajo community members. Now of that, we only have one State paved road going through that community, and we have only 26 miles of paved road which was

put in place by the Bureau of Indian Affairs. Now the rest, 281 miles, is unimproved dirt roads. Now only 6 miles of that is gravel, and we are busing 98 percent of our students on those roads. And during the months of January, February, and March, those dirt roads, 280-some miles, become impassable for about 3 months——

Mr. LEHMAN. Would you put that in a message to me? We'll have Mr. Barnhart, the head of the Federal Highway Administration, testify before our committee in March, and I would like to present him with this information.

Chairman MILLER. You know, I first worked on an Indian reservation when I was in high school, and I never understood why Indians had so many cars. But then the other day, when we were driving around one of the reservations, I understood why. It's because they don't last very long.

Mr. COHOE. Yes, thank you for that comment. I would like to present that document, because otherwise if I send it through the proper channels, it will never get there.

Chairman MILLER. Send it to the committee, and we'll get it to the chairman.

Mr. COHOE. I appreciate it. Thank you.

Chairman MILLER. Thank you very much for your help. Again, I would hope that as you go back to your tribes, you would start to think about this. Because if there is general agreement that something like this should be done, I would like to go back to the Interior Committee and I would like to get on with it as we start to write the Federal budget, because this is going to be a very ugly year in terms of Federal budgets.

And again I would like to thank Congressman Wheat and Congressman Lehman for joining us today. Thank you very much. The committee will stand adjourned.

[Whereupon, at 11:55 a.m., the committee was adjourned.]

[Material submitted for inclusion in the record:]

PUEBLO DE SAN ILDEFONSO
TEWA
NEW MEXICO 87532

(505) 455-2273

J. GILBERT SANCHEZ
GOVERNOR

GARY S. ROYBAL
1ST LT. GOVERNOR

TRIBAL COUNCIL
EDMUND GONZALES
JOHN GONZALES
FRANK MARTINEZ
ALFRED AGUILAR
SANTIAGO SANCHEZ
MARTIN W. AGUILAR
LOUIS NARANJO, JR.
ELMER TORRES
JOE T. SANCHEZ
PERRY MARTINEZ
JOSE V. AGUILAR, SR.
JUAN TAFOYA

FEB 12 1986

January 30, 1986

The Honorable George Miller
Chairman, Select Committee On
Children, Youth, And Families
385 House Office Building Annex 2
Washington, DC 20515

Dear Mr. Miller:

Enclosed is testimony affecting Native American Children, Youth, and Families at Eight Northern Indian Pueblos Council. Pursuant to requests for testimonies at the public hearing held at the All Indian Pueblos Council in Albuquerque on Friday, January 10, 1986.

Several Eight Northern Indian Pueblos Council representatives were in attendance during this public hearing and we appreciate the support given by you, Congressmen William Lemman and Alan Wheat.

The attached testimonies affect Native American Children, Youth, and Families in New Mexico. We feel confident that your continued investigation into the conditions addressed in our testimonies will provide you with a broader perspective of our needs in these areas. Please contact me at (505) 455-2273 should you need additional information.

Sincerely yours,

J. Gilbert Sanchez

J. Gilbert Sanchez, Chairman
BOARD OF GOVERNORS
Eight Northern Indian Pueblos Council

Enclosures:

BEST COPY AVAILABLE

Page 1

Testimony Affecting Native American Children, Youth, and Families at Eight Northern Indian Pueblos Council.

Indian Child Welfare Act (ICWA).

Two areas of major concern are:

1) inadequate funding to implement the Indian Child Welfare Act, and
2) the impact of this Act because of the vested authority in the Assistant Secretary of the Interior and delegated to the Bureau of Indian Affairs to promulgate statutes and regulations pertaining to the Act without soliciting tribal input.

The amount allocated to operate programs under the Indian Child Welfare Act has been at the same level for the last four years, that is around 8 million. This cause enormous concern for projects that have been funded for the last several years at the same level in that each year the level of service activity has to be drastically reduced. The inflationary trend experienced the last several years has eroded into any gains that had been accomplished previous. The current funding formula does not leave any opportunity for successful projects to achieve stability of growth, because there is a ceiling on the funding available.

The other major concern with the implementation of the ICWA is the authority vested in the Assistant Secretary of the Interior and delegated to the Bureau of Indian Affairs to issue and revise rule and regulations pertaining to the Act. There have been changes that have had an adverse and serious impact on our project and we feel tribes and other grantees should definitely have some input when regulations are changed. We recommend that any changes proposed should require public hearings.

61-183 O - 86 - 4

BEST COPY AVAILABLE

Tribal Courts and the U.S. Attorney's Office.

There is a void between tribal courts and the U.S. Attorney's Office. This void is caused because tribal courts lack jurisdiction under the provisions of the Major Crimes Act. As a result, cases that are referred to the U.S. Attorney's Office go unprocecuted.

Consequently, there is a need for an Indian Tribal Juvenial Judge that would have the authority to prosecute all cases involving children (i.e., physical and sexual abuse, neglect and abandonment and custody proceedings).

This Indian Juvenile Judge would serve the eight pueblos and would need to have the authority to prosecute any crime involving children and be able to levy sentence according to the crime and not be restricted to the current limitations that the tribal court experiences. Part of these limitations are lack of financial resources for treatment and incarceration.

Child Abuse and Neglect.

The Eight Northern Pueblos Indian Council Governors have recognized child abuse and neglect as a serious and growing problem among their pueblos, as is true with the nation as a whole. Over half of the children from these communities identified as having been abused or nelgected have family members who abuse alcohol and/or drugs. While the governors recognize that alcohol does not cause child abuse or neglect, it is clear that family alcohol abuse lowers parents' control over lashing out at their children when under stress and hurts parents' ability to care for their children. In addition, abused and neglected children are at greater risk for abusing alcohol and drugs, for other self-destructive and delinquent

BEST COPY AVAILABLE

behaviors, such as suicide, and, when adults, abusing and neglecting their own children.

Statistics on abused and neglected children have been gathered by the Child Protection Team at the Santa Fe Service Unit Hospital, Indian Health Service, since December 1982. The Santa Fe Service Unit serves 12 tribes, 8 of which are the Eight Northern Indian Pueblos. Population size varies from 100 to 1600 per community, with a total population of over 7500. Since December 1982, the Child Protection Team has listed 107 children (including siblings) as abused or neglected, representing 60 families. Hospital service providers state that these numbers "only scratch the surface:" for every child identified at least 6-8 more children are known to be abused or neglected, but have not come to the hospital for services. Over half of the children identified come from the communities served by the Eight Northern Indian Pueblos Council.

What is also alarming is the number of adults receiving mental health or social services at the Indian Hospital who report being abused or neglected as children. Although statistics have not been collected on these adults, it is indicative of what is recognized by authorities and health providers as fact: child abuse and neglect is a problem that is passed on from one generation to the next.

At present, program services at all levels - agency and tribal - are not capable of addressing the needs of these children, their families, and adults who were abused as children. Yet, without serious intervention and prevention efforts right now, many more families will suffer in the future, and increase the need for services far beyond what are presently needed.

Efforts have been made to create community awareness as to the effects of child abuse and neglect on children, their families and communities, as

BEST COPY AVAILABLE

well as related issues of alcoholism and domestic violence. Along with the Child Protection Team at the Indian Health Service hospital, a Community SCAN (Suspected Child Abuse and Neglect) Team was also organized three years ago. This team, made up of community health providers and Indian Health Service, Bureau of Indian Affairs, and State service providers, along with tribal and BIA police and tribal judges, has addressed the need for community awareness, foster care within the pueblos (see Eight Northern Indian Pueblos Council resolution on foster care, November 13, 1984), the development of tribal child protection teams (or multidisciplinary teams; see resolution by Santa Clara Pueblo, September 9, 1985), and the need for federal legislation which will enhance the ability of the federal government and the tribal courts to incarcerate, prosecute, and order treatment for offenders.

But this is only the beginning. In order to fully meet the needs of these and other Indian communities to break the cycle of child abuse, and neglect, all out prevention efforts to educate parents, children, and other service providers, including medical staff, are vitally needed now. Further, intervention services must be strengthened and coordinated to assure appropriate treatment for children and families and timely prosecution for offenders. The coordination between service providers and legal personnel is especially crucial since, in the past 6 months, we have been seeing far more sexual abuse of Indian children come to light.

We do not have the resources or personnel to meet the needs. In fact, this year (FY 86) we have lost numerous key resources and personnel due to budget cuts. Further, we have never had the resources or facilities to properly prosecute, incarcerate and treat offenders.

We are asking for federal legislation to provide the vehicle for developing these resources at the local level: 1) on-going prevention and education

BEST COPY AVAILABLE

efforts to end the cycle of child abuse and neglect; 2) an incarceration facility and resurces for appropriate intervention, including prosecution and treatment, and 3) clarification of jurisdiction issues between tribal courts, the State, and the U.S. Attorney's Office to assure timely and appropriate legal response.

Substance Abuse, Prevention, Treatment and Control.

This testimony is supported and commonly addressed by our Governors as well as Indian Tribes nationwide.

A quote is taken from one of our Wise Indian Leaders who once said "My VALUED people it has been our misfortune to welcome OUR FRIEND the White Man. We have been deceived. He brought with Him shining things that pleased our Minds, he brought with Him weapons more effective than our own. Above all, he brought with Him the SPIRIT WATER that makes us forget old age, weakness and sorrow. I wish to say to you, My Dear People, if your wish is to possess and accept these things for yourselves, YOU, must begin anew and put away the Wisdom of your Fathers." Down through the centuries that our Fathers and their Fathers have lived on this Planet, we can only accept that the addiction of ALCOHOLISM that YOU gave to our Indian People at a BARGAIN, has now become not only OUR Number ONE, NUMERO UNO Health problem, but also, PUEBLO Enemy Number One and the Cause of Many other Problems re-LATED to Alcohol.

The outstanding PREVENTION model at the Eight Northern Indian Pueblos Council is the San Juan Pueblo Dance Group. It is important to mention that the Tribal Courts on this Pueblo referred the Indian youth that were once labeled as incorrigibles. The young adults had a need to identify with their Indian Culture. Through these trying times, the youth requested of prevention program a different approach which involved the teaching of their

BEST COPY AVAILABLE

Native culture and dances. The outcome had a tremendous impact not only on the youth themselves but also their parents which in effect culminated in:

1 -- having a closer friendship in which each one values the other

2 -- learning a new skill that is appreciated and valued by one's peers

3 -- being accepted by peers even when one makes mistakes

4 -- learning about the participation in one's cultural heritage.

The other end results not less important is the positive development of our young adults, spiritually, psychologically and physiologically which results at retaining of our heritage and culture which are invaluable to all human beings on this planet.

At the Eight Northern Indian Pueblos Council, the methodology incoporated for preventing, treating and controlling alcohol abuse and alcoholism are a unique half-way house treatment center for recovering alcoholics that employs vocational training and a small scale farm and livestock project. The goal being self-sufficiency through a hands on-approach which would impact on agricultural and economic development at the Pueblos. The half-way house prepares the recovering alcoholic to re-enter a family and community evnironment with meaningfully and purchasable skills.

We at the Eight Northern Indian Pueblos Council will nuture the concepts of **CONTROL** by the development and implementation of the following criteria:

1 -- Will identify causal factors associated to alcohol abuse in Native American communities.

2 -- Based upon the identification of the causal factors we plan to develop Native American geared alcohol and alcoholism Edcational programs.

3 -- Educational material will be adapted to relate to all Native American communities.

4-- Training needs will be based on research findings and the development of alcohol prevention modalities for Pueblo Indians, tribal, urban and rural populations.

10301

BEST COPY AVAILABLE

5 -- All of these was performed with the goal of creating concepts of total therapeutic communities.

6 -- Based upon research conclusion, all of this supports the goal of developing totally therapeutic communities from primary prevention to secondary prevention and including tertiary prevention.

We are doing this in a very minute scale because our facilities and our human resources are limited.

Senator Andrews in his introduction of S. 277, stated a need to continue targeting federal resources to address the health problems of Indians. **"While most Americans - 66.4 percent - will live to age 65 or older, the Indian child born today has only a 35 percent chance of reaching age 65. The fact is that 40 percent of all Indian people will die before they reach 45. These are realities that we cannot afford to ignore."**

In conclusion, with the 300 Indian Tribes nationwide who are faced with this No. 1 killer and enemy, WE feel that SB 400 will have a tremendous impact on our lives in the future for not only us but for our future generations. This will give US the tool to continue the research, development of alcoholism prevention models and substance abuse control through education to bring awareness to Indian People of the devastating effects of alcohol to our spiritual physical and mental well being.

Therefore, we need 10 million dollars to replicate this modal which will provide services to all tribal members that need it in the area of prevention, treatment, and control of substance abuse -- funding that will provide a positive impact on our Indian society. We need this funding enable is to train our own people in prevention, treatment, and control of substance abuse.

BEST COPY AVAILABLE

Page 8

Community Health Representative Program.

The Community Health Representative program has been a viable and necessary program since 1969 when it first began. This program is endanger of folding if the refunding does not occur for the coming years. Many viable services have been provided for the Indian population on the reservation which range from home visits to health education. Disease prevention and control are provided, with the continued follow up services and monitoring of clients for the medical providers. Included with this testimony are statistical data that has been submitted by the Eight Northern Community Health Representatives on the services that they are providing.

If this program is cut as it is presently proposed, major changes in the health of our people would occur. Infant mortality would probably be seem again, there would be an increase of disease such as hypertension and diabets out of control. The severity of injuries due to accidents would rise without this prevention program. As it is, the CHRs' provide emergency care for the injured and the ill and without them, the trauma would become more severe without the assistance of the CHRs' providing stabilization. Services provided by the Public Health Nurse could not possible and adequately meet the health needs of the communities, since these persons are limited in the time that they spend in the communities. Daily contact in the communities would be impossible.

Transportation is also an essential part of the services that are provided since many of our people do not have transportation available to get them to a medical facility for needed medical care.

BEST COPY AVAILABLE

Page 9

STATISTICAL DATA FOR THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM FOR THE MONTHS OF OCTOBER THRU MARCH

Home visits	-	Over 7,000 home visits have been provided by 33 CHRs' for the follow-up and monitoring of illnesses or disease, for case findings of new illnesses or disease.
Interpretation	-	The CHRs' provide interpretation to those clients not understanding the English language, medical directions and advise, and the directions on how to take medication that is prescribed.
Referral from	-	Over 1,000 referrals from medical providers have been received that the CHRs' have taken care of for the monitoring or checking up on clients for the physicians.
Deliveries	-	Over 1200 deliveries have been made by the CHRs' which consist of delivering appointments, medication, medical supplies, information from IHS that keep clients up to date on medical care and information.
Health Education	-	The CHRs' are providing health education to over 2,000 clients. Education in the health areas such as safety, hypertension, diabetes, dental care and many more areas of health are being covered.
Follow-up Services	-	CHRs' are providing more than 2,000 follow-up services to clients checking up on illnesses or disease for close monitoring to prevent serious problems from occuring.
Referrals to	-	The CHRs' have referred more than 3,000 clients to a medical facility for medical care because of illnesses that need medical attention,accidents that have caused injury, and for the medical follow-up of disease such as hypertension control.
Transportation	-	Many clients do not have transportation accessible to them and rely heavily on the CHR program for needed transportation to the medical facilities. Over 3,000 clients have been provided transportation services.
Personal Care	-	This area consists of providing services such as daily personal hygiene to those clients that

BEST COPY AVAILABLE

		are handicapped, or because of illness cannot take care of themselves without some assistance. Also provided are the checking vital signs and blood pressures because of illnesses or disease. The CHRs' are also providing foot care for the diabetics with the weekly checking of feet of the diabetic to prevent serious medical problems of the diabetic. Over 1,500 services have been provided in this area.
Screening	-	This is an area that the CHR will do daily to prevent health problems. Either by the checking of blood pressures or having community programs set up for the screening of other diseases or problems. This is also used for safety prevention.
Emergency Medical Svcs.	-	The CHRs' provide emergency medical care in the communities whenever and injury has occurred. They are either first responders or EMT's that work closely with the ambulance services in their areas. The majority of the CHRs' man these ambulance services as a part of their daily job description.

The CHRs' have very busy schedules as you can see. The average number of miles that a program puts on their vehicles each month range from 700 to 2, 500 miles per month. Most CHRs' work over the 40 hours per week that they are getting paid for with no type of compensation for the extra hours that they give to their communities.

BEST COPY AVAILABLE

New Mexico Indian Elderly and the Impact of Good Nutrition and its Relationship to the Improved Mental and Physical Health:

This testimony is submitted in behalf of the New Mexico Indian Council on Aging which represents approximately 8,000 Indian elderly of the 19 pueblos of New Mexico and two Apache tribes: Taos, Picuris, San Juan, Santa Clara, San Ildefonso, Pojoaque, Nambe, Tesuque, Jemez, San Felipe, Santo Domingo, Isleta, Cochiti, Sandia, Santa Ana, Zia, Zuni, Laguna, Acoma, Jicarilla, and Mescalero.

What makes us elderly Indians a unique population? Let us go back to the time when we were self sufficient--we raised our own crops, weaved our own cloth and made our own traditional attires, and built our own homes! Down through the centuries our fathers and their fathers have lived on this land, it is the creation of the "grass roots" which prompts me to be here today, rather submit this testimony. Because of our pride of being an Indian, we have preserved our self-identity. This we have done through the continued cultural feast activity which requires preparation to strengthen our spiritual well-being and which is expressed through dancing and other religious ceremonies.

Because of societal changes, lifestyles have changed for us Indians, also. We are living in two worlds. Our Indian people willingly joined the Armed Forces to defend our country during World War II, which was the turning point, and upon our return to our reservations we brought with us new ways of living. Life styles began to change: we experienced industrial and technological changes which have had a significant impact in our nutrition, physical and mental health. No longer were we grinding our own corn and raising our own livestock and crops, we were exposed to other conveniences. Fodd preservations overpowered or corn meal and Atole! Diets changed. Also, there was no longer a need to work out in the fields and cultivate our land, substantial-paying jobs were obtained in neighboring communities and urban settings. These life styles have created obesity and other physical and mental health problems.

BEST COPY AVAILABLE

Today we still experience our pride of being an Indian. We continue our festival ceremonies, eat our traditional food, but the changes of life styles throughout the years have created concerns we wish to address: values and work ethics are unique among us, the Indian population. Because of other cultural exposure we find a need to strengthen these values and instill them in our youth and middle-aged adults in order to preserve our heritage.

Statistics indicate life expectancy for Indians is low in comparison to other ethnic groups; there are approximately 8,000 elderly Indians in New Mexico facing numerous problems in the areas of nutrition, physical and mental health.

Our senior Citizens Programs are providing our elders with one nutritional meal four or five times a week. THIS IS NOT SUFFICIENT. We are in dire need of a more comprehensive array of services for our elderly to include not only the one prepared meal per day, but to motivate and instill in each and every elder the desire to change his or her nutritional intake, and change the method of food preparation in order to ensure a healthier and stronger individual. These services should include provisions for social activities and personal growth, including physical fitness programs. We re in dire need of additional facilities to provide adequate basic needs and other recreational and social activities, and trained staff to work closer with our elderly! Nutritional education is the vehicle to create attitude changes and eating habits which in turn will reduce obesity, dependence on alcohol and drugs. This will greatly decrease heart conditions, cancer, diabetes, hypertension, and other fatal diseases. Because many of us live in reservations, transportation to health facilities and healt providers is extremely difficult. We need in-home care services to eliminate institutionalizing our elderly. In conclusion, we need financial resourses to meet these needs outlined here.

BEST COPY AVAILABLE

TAOS DAY SCHOOL
P. O. DRAWER X
TAOS, NM 87571
PH:505/758-3652

Representative George Miller, Chairman
Select Committee on Children, Youth
& Families
U.S. House of Representatives
385 House Office Building Annex 2
Washington, D.C. 20515

January 15, 1986

Dear Representative Miller,

Your committee's concern for Native Americans was greatly needed and appreciated. In my sixth year as principal of Taos Day School at Taos Pueblo, my awareness of problems steadily heightens and my attempts to cope become increasingly frustrated.

Santa Clara Day School's principal, Solomon Padilla, Jr. and I agreed about the "thrust" of your committee's hearing(s). Unless we were terribly mistaken, you wished to determine just how was the Indian at poverty level unique compared to poverty level citizens elsewhere. Permit me to respond within my own experiences/observations and please grant that I have few comparisons with "elsewhere."

As Mr. Padilla and I indicated to you immediately after adjournment, 46% of P.L. 94-142 money failed to reach children. In conjunction, "positions" get created to employ personnel, to build empires, to satisfy political demands, to dilute work loads, and to gather personal support. This "welfare with dignity" siphons off much needed revenue by virtue of wasted salaries and benefits. Qualifications, minimal as might be required, are majorally ignored. Although not exclusively to blame, the Indian Preference Law delights some tribal leaders who have availed themselves of opportunities for purely political reasons since 1974. Meantime, poverty level Indian children fail to receive the benefit(s) which that money could buy in necessary supplies, materials, instructional personnel, equipment, etc.

Northern Pueblos Agency has five non-residential day schools populated by no more than 355 students, total. The Agency office in Santa Fe consists of six assigned personnel at a salary cost of nearly $160,000 per year. Adding in the cost of vehicles, utilities, supplies, and equipment, it could realistically drive the total cost up to $200,000. This needless "overhead" of over $560 per student is spent before any books, supplies, materials, equipment, fuel (bus and heat), utilities, teachers, food, transportation, etc., are purchased. $200,000 would purchase between ten and thirteen teachers' salaries and would be money much better spent on Indian children.

Numerous hiatuses in federally funded services occured due to mismanagement by the "Agency", almost entirely comprised of the aforementioned "welfare" recipients. The question we school personnel can never get answered is,

BEST COPY AVAILABLE

what happened to or what was done with the budgeted money during the period(s) that we were without a Speech Therapist or a Diagnostician, for example? Central Office personnel shed no more light upon our questions and concerns than the Agency does.

As I stated to Representative Lehman in the lobby, Indians have great expectations, constantly brought to them or literally forced upon them which never materialize. In five and half years a good two dozen state or federally funded people have sat down in my office to describe their "program" which they would bring to our children and teachers in their classrooms. These programs in the main were "prevention" of alcohol abuse, drug abuse, child abuse, etc. Many of these people represented Indian organizations such as Eight Northern Pueblos Council (ENIPC) or the All Indian Pueblos Council (AIPC). Many glowing presentations were made to our Board of Education for their information and approval. Yet, 99% of these people were never seen nor heard from again. In a word, one almost out of our vocabularies, "followup" is non-existent. As Rep. Lehman said to me, "The Indian people are (their) inventory." From that remark, I believe Congressman Lehman is familiar with the waste of funding.

In a different vein, may I say that economic development makes sense. Combined with education, it can turn the situation around. Royalty checks, welfare payments, food stamps, etc. only exacerbate the problem(s). Direct involvement with, and employment in, a viable tribal economic effort makes the best sense. Isolation is the main negative factor weighing against such effort in some areas/tribes, however. Native Americans are uniquely tied to their land and their traditions. That cannot be tampered with but somehow they must also be accomodated on their terms.

Lastly, the timing of your hearing(s) may have been reason for the small attendance in Albuquerque. Except for a few pueblos, San Ildefonso for example, new tribal officials were just taking office and becoming acquainted with their duties in early January. They were not yet ready to engage in heavy discussions of problems, etc.

Since the Select Committee was obviously not bipartisan, how will these hearings then translate into congressional action/legislation? It is hoped that Congress will first try to economize in the areas of "programs" unnecessary unqualified personnel, better distribution of funding, consolidation as opposed to duplication, etc. before the urge to "throw money" at the problem inevitably occurs.

Sincerely,

Roy French, Principal

xc: Representative William Lehman

BEST COPY AVAILABLE

PREPARED STATEMENT OF CHRIS A. BAKER, CHAIRMAN, SOUTHERN UTE INDIAN TRIBAL COUNCIL

THANK YOU FOR GIVING ME THE OPPORTUNITY TO SHARE MY THOUGHTS WITH YOU TODAY ON A MATTER OF GREAT CONCERN TO ALL OF US. I KNOW OF NO ONE WHO HAS NOT HAD TO DEAL WITH PROBLEMS CREATED BY ALCOHOLISM - EITHER AT WORK OR AT HOME OR BOTH.

ALCOHOLISM IS THE #1 CONCERN ON THE SOUTHERN UTE INDIAN RESERVATION AND SHOULD BE THE #1 CONCERN FOR EVERY OTHER RESERVATION, TOWN, CITY, AND SCHOOL IN THE UNITED STATES.

A LOT OF GOOD WORK HAS BEEN DONE IN THE AREA OF ALCOHOLISM IN THE PAST FIFTEEN YEARS. THE FIRST STEP FOR SOUTHERN UTE WAS TO JUST LIFT THE BLINDERS AND ADMIT THAT ALCOHOL HAD US IN ITS GRIP. THE SECOND WAS TO THROW AWAY THE OLD THINKING ABOUT ALCOHOLISM AND THE STIGMA ATTACHED TO THE PROBLEM. THE PERSON SUFFERING FROM ALCOHOLISM IS NOT WEAK, AND HE IS NOT IMMORAL. HE OR SHE IS THE VICTIM OF A DISEASE. DIABETES IS ANOTHER DISEASE THAT PLAGUES INDIAN COUNTRY. DO WE SAY THAT IF THE DIABETIC CAN'T CONTROL HIS DISEASE THAT HE SHOULD BE IGNORED AND LEFT TO DIE IF HE FAILS TO OVERCOME ITS EFFECTS? NO, WE STRONGLY ENCOURAGE THIS INDIVIDUAL TO SEEK TREATMENT, WE PROVIDE DOCTORS, CLINICS, HOSPITALS, AND MEDICATIONS, WE EMPLOY VISITING NURSES AND COMMUNITY HEALTH REPRESENTATIVES TO PROVIDE FOLLOW-UP CARE, WE CONDUCT SPECIAL DIABETIC CLINICS; ETC. IS ALCOHOLISM REALLY ANY DIFFERENT? YES, THE SIDE EFFECTS CREATED BY ALCOHOLISM SUCH AS FAMILY VIOLENCE AND OTHER EQUALLY DISTASTEFUL PROBLEMS PRESENT A

MORE UNPLEASANT IMAGE TO THE PUBLIC BUT IN REALITY, IN THE EARLY STAGES OF THE DISEASE OF ALCOHOLISM, IS THERE ANY REAL DIFFERENCE?

TRADITIONALLY, INDIAN HEALTH SERVICE HAS PROVIDED THE DOLLARS NEEDED FOR ACUTE CARE OF THE ALCOHOLIC, BUT HAS BEEN RELUCTANT TO PROVIDE FUNDS FOR PREVENTION, EARLY INTERVENTION, AND ALCOHOLISM TREATMENT PER SE. THIS IS KIND OF LIKE CLOSING THE BARN DOOR AFTER THE HORSE IS OUT. BACK TO DIABETES, WHAT WOULD HAPPEN IF DIABETICS WERE ONLY TREATED IN THE FINAL STAGES OF THEIR DISEASE? WHAT WOULD HAPPEN IF TREATMENT WAS WITHHELD UNTIL RENAL FAILURE SET IN? IF THAT WERE THE CASE, WE WOULD SEE SHOCKING STATISTICS LIKE THOSE THAT DEAL WITH ALCOHOLISM. WE'VE GOT TO CHANGE OUR THINKING AND BEGIN ATTACKING THE PROBLEM OF ALCOHOLISM BEFORE THE PATIENT IS TERMINAL.

AT SOUTHERN UTE, WE'VE SPENT A LOT OF TIME AND EFFORT WITH THE TERMINAL PATIENT. WE'VE MOVED FROM A BAND-AID APPROACH TO A COMPREHENSIVE PROGRAM OF SERVICES, WHICH INCLUDES: NON-MEDICAL DETOXIFICATION, PRIMARY RESIDENTIAL TREATMENT, REHABILITATION AND FOLLOW-UP. IT DIDN'T TAKE LONG FOR US TO REALIZE THAT NO ONE METHOD WORKS FOR EVERY INDIVIDUAL SO OUR PROGRAM IS FLEXIBLE ENOUGH TO ALLOW FOR TRADITIONAL INDIAN MEDICINE TO AA TO ANTEBUSE TO ACCEPTED COUNSELLING PRACTICES SUCH AS ONE TO ONE, GROUPS, AND FAMILY COUNSELLING. WE'RE EXPANDING OUR EFFORTS NOW TO INCLUDE PREVENTION AND EARLY INTERVENTION.

OUR PREVENTION EFFORTS HAVE FOCUSED ON PROVIDING YOUNG PEOPLE WITH OTHER POSITIVE ALTERNATIVES, THE USE OF POSITIVE PEER PRESSURE, AND INCREASED POSITIVE SELF-IMAGE. YOU'VE GOT TO "ACCENTUATE THE POSITIVE AND ELIMINATE THE NEGATIVE."

WE HAVE ESTABLISHED PREVENTION ACTIVITIES FOR THE YOUTH IN OUR AREA. ONE OF THE BIG PROJECTS WE'VE DONE IS THE ANNUAL "RUN AGAINST DRUGS" FROM IGNACIO TO DENVER (350 MILES) RELAY STYLE. THE "RUN AGAINST DRUGS" IS THE YOUTH'S WAY OF EMPHASIZING THAT THEY DO NOT HAVE TO BECOME THE PART OF THE NORM. THE FIRST YEAR (1984) 40 OF OUR YOUTH RAN. THIS YEAR (1985) 40 OF OUR YOUTH RAN WITH 4 OTHER COLORADO COUNTIES BECOMING INVOLVED (TOTAL 100 YOUTH). THIS YEAR (1986 IN JUNE) PROMISES TO BE EVEN BIGGER WITH ANOTHER 5 COLORADO COUNTIES WANTING TO BECOME INVOLVED. WE HAVE ALSO OBTAINED A BUILDING AND ARE IN THE PROCESS OF RENNOVATING IT FOR A TEEN CENTER WHICH WILL BE USED FOR RECREATIONAL AND EDUCATIONAL PURPOSES. A COUPLE OF PROGRAMS WE WOULD LIKE TO START FROM THIS BUILDING ARE A BIG BROTHER, BIG SISTER PROGRAM AND THE YOUTH TUTOR PROGRAM. EARLY INTERVENTION IS A NECESSARY ADJUNCT TO THE PREVENTION IDEA. PREVENTION EFFORTS ARE A GOOD WAY TO IDENTIFY EARLY INTERVENTION NEEDS.

EDUCATIONAL AND PREVENTION EFFORTS IN THE SCHOOL HAVE LED DIRECTLY INTO EARLY IDENTIFICATION AND INTERVENTION ACTIVITIES.

WE HAVE ESTABLISHED A GOOD RAPPORT WITH THE SCHOOLS AND SCHOOL PERSONNEL. WE DO EDUCATION GROUPS, GRIEF GROUPS, SUICIDE GROUPS AND CRISES INTERVENTION. SELF-AWARENESS, SELF-ESTEEM, POSITIVE PEER GROUPS, AND LIFE SKILLS ARE ALSO AMONG SOME OF THE CLASSES WE HAVE INITIATED WITH THE SCHOOLS. OUR PREVENTION PRESENTATIONS WITH OUR YOUTH ARE CONDUCTED IN THE IGNACIO SCHOOLS AND AS WELL AS OUTSIDE OF OUR IMMEDIATE AREA.

OTHER EARLY INTERVENTION EFFORTS AT SOUTHERN UTE INCLUDE AN EMPLOYEE ASSISTANCE PROGRAM (EAP) THAT IS DESIGNED TO ELIMINATE THE "KILLING WITH KINDNESS" SYNDROME AND EMPHASIZE THE "TOUGH LOVE" CONCEPT. WE'VE FOUND (THROUGH YEARS OF TRIAL AND ERROR), THAT WHEN WE TRY TO GIVE THE EMPLOYEE ANOTHER CHANCE WHEN ALCOHOL IS INVOLVED IT BECOMES ANOTHER CHANCE AND ANOTHER CHANCE AND ANOTHER CHANCE. WE'RE JUST HELPING TO DRIVE THE NAILS IN THEIR COFFIN (OR KILLING THEM WITH KINDNESS). AS A TRIBAL ORGANIZATION, WE'VE DECIDED TO TRY A DIFFERENT APPROACH WHEN ALCOHOL BEGINS TO COMPROMISE AN EMPLOYEE'S ABILITY TO PERFORM ON THE JOB - WE ARE HITTING THEM WITH THE "VELVET GLOVE." WE ARE TELLING OUR EMPLOYEES THAT WE CARE TOO MUCH ABOUT THEM TO DRIVE NAILS IN THEIR COFFIN. WE ARE GIVING THEM THE MOTIVATION TO SEEK TREATMENT BEFORE THE JOB IS GONE, BEFORE THE FAMILY IS GONE, BEFORE THE HEALTH IS GONE AND WHILE THEY HAVE REASON TO LIVE. EMPLOYEES ARE ALLOWED TO SELECT THEIR OWN OPTION FOR TREATMENT; THEY ARE ALLOWED TO ASSUME RESPONSIBILITY FOR THEIR OWN LIFE AND THEIR OWN REHABILITATION BUT THEY

RECEIVE THE SUPPORT THEY NEED ALL THE WAY UP TO THE TRIBAL COUNCIL. THE TRIBAL COUNCIL FORMULATED THE EMPLOYEE ASSISTANCE PROGRAM POLICY AND WE LIVE BY THAT POLICY. THE POLICY IS CARRIED OUT CONSISTENTLY TO EVERY EMPLOYEE REGARDLESS OF TITLE, RANK, FAMILY RELATIONSHIP; ETC. TOUGH LOVE IS THE HARDEST KIND OF CARING BUT IT MEANS CARING SO MUCH THAT YOU ARE WILLING TO SACRIFICE A FRIENDSHIP, FACE AN ANGRY AND HURT EMPLOYEE, ENCOUNTER UPSET FAMILY MEMBERS; ETC. ITS KIND OF LIKE A SURGEON, WHEN THE SURGEON PICKS UP THE KNIFE TO CUT OUT THE CANCER, HE KNOWS HE IS GOING TO CAUSE A LOT OF PAIN FOR THE PATIENT AND MAYBE EVEN DEATH - BUT HE DOES IT ANYWAY - ITS WORTH EVERYTHING IF IT SAVES THE PATIENT'S LIFE.

TO SUM UP MY REMARKS TODAY, I CAN ONLY SAY:

RECOGNIZE AND ACCEPT ALCOHOLISM FOR WHAT IT REALLY IS - A #1 KILLER AND A #1 PROBLEM NOT JUST FOR US BUT FOR OUR FRIENDS AND NEIGHBORS AS WELL.

STOP KILLING YOUR FRIENDS, NEIGHBORS, AND FAMILY MEMBERS WITH KINDNESS. BECOME A PART OF THE SOLUTION, NOT A PART OF THE PROBLEM. LET'S STOP HELPING EACH OTHER TO DEATH.

GET TOUGH - WITH LOVE. USE THE VELVET GLOVE. SET UP GOOD, WORKING EMPLOYEE ASSISTANCE PROGRAMS. HELP YOUR EMPLOYEES AND CO-WORKERS BEFORE IT'S TOO LATE.

- 5 -

PRESS FOR RECOGNITION OF THE NEED TO FUND PREVENTION AND EARLY INTERVENTION ACTIVITIES. START WITH YOUR OWN HEALTH BOARDS AND TRIBAL COUNCILS AND WORK RIGHT ON UP TO THE PRESIDENT'S DESK.

PRESS FOR RECOGNITION AND TREATMENT OF ALCOHOLISM AS A DISEASE. AS INDIVIDUALS - SET A GOOD EXAMPLE FOR YOUR CHILDREN, YOUR BROTHERS AND SISTERS AND YOUR NIECES AND NEPHEWS. LET'S SHOW THE KIDS THAT IT IS FUN AND OKAY NOT TO DRINK. BE A POSITIVE ROLE MODEL.

WE IN INDIAN COUNTRY REALIZE THAT ALCOHOL IS OUR NUMBER ONE PROBLEM. WE HAVE HAD MANY STUDIES WHICH INDICATE A DIRE NEED TO DO SOMETHING BUT WE ALWAYS WAIT, HOPING THAT SOMEONE ELSE WILL FIND THE ANSWER TO ALLEVIATE OUR PROBLEMS. THE SOLUTION IS SIMPLE - ACTION.....GET INVOLVED....LET'S FIGHT THIS CANCER BEFORE IT'S TOO LATE.

SUBMITTED BY: Chris A. Baker

CHRIS A. BAKER, CHAIRMAN
SOUTHERN UTE INDIAN TRIBAL COUNCIL

PREPARED STATEMENT OF BENNIE COHOE, EXECUTIVE DIRECTOR, RAMAH NAVAJO SCHOOL BOARD, INC., PINE HILL, NM

ADDENDUM STATEMENT BY BENNIE COHOE, EXECUTIVE DIRECTOR

TESTIMONY TO HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH & FAMILIES

JANUARY 24, 1986

In my prepared statement to your Committee of January 10, 1986, I outlined some of the accomplishments of the Ramah Navajo Community, then emphasized three key issues confronting our development, and finally offered some recommendations for change.

The present package is to be included as an addendum to that prepared statement. Included are documents which address the needs of our children, youth, and families from the various perspectives of different programs of the Ramah Navajo School Board.

My own additional comments are included here, for the purpose of going beyond my original prepared statement to impress upon the committee some of the deeper causes underlying the symptoms which we all spend our time wrestling over.

My original recommendations to you were based on a continuity in the relationship between the U.S. Government and Indian tribes. Since it is one of the purposes of your Committee to generate interest and concern about the status of Indian children, youth, and families, I thought it appropriate to share these additional thoughts with you, which look toward more fundamental changes and a discontinuity in intergovernmental relationships.

BEST COPY AVAILABLE

TOWARD A NEW ENVIRONMENT FOR DEVELOPMENT

You have by now received reams of data and statistics on the social and economic status of Indian families and communities: Unemployment 5 to 10 times the national average; Social statistics illustrating massive cultural and socioeconomic breakdown; Uninspiring educational achievement by our young. . .

Obviously, something has gone wrong. To ascribe these problems to the inherent weakness or perversity of the Ramah Navajo People or of the Indian Race would be justifiably condemned in the eyes of modern world opinion and humane ethics. On the contrary, many of the above statistics and references represent symptoms of a deeper cause: the "disease" of chronic dependency. A major source of this disease is the past and continuing violation by non-native society of the human rights of entire communities and nations of Indian people. Another principal source of the disease is the debilitating and fundamentally unhealthy relationship between the U.S. Government and these Indian communities and nations.

I will explain what I mean by these bold comments; and then will follow with a set of recommendations regarding fundamental changes required to overcome the disease. I will use my own community as a reference point for many of these comments, but similar conclusions can be drawn from experiences across Indian Country.

BEST COPY AVAILABLE

The rights of the Ramah Navajos to a homeland were violated first by the forced intrusion of non-native peoples into our region; our subsequent banishment from our lands to Ft. Sumner in the 1860's; and then, following our return to portions of our previous lands (no longer truly our own) in 1868, the underhanded expropriation of our lands by non-Indian settlers, urged on by legislative incentives in Washington.

As a conquered nation, we embarked upon more than a century of forced dependency, in which our worthiness as human beings was measured only by how closely we approximated the dominant society's values and lifestyle. Our rights of land ownership and of self-governance were stripped from us, and federal "services" and subsidies served to maintain our condition of subjugation, rather than to re-build our independence. Thus began the unhealthy relationship between he U.S. Government and our People.

The unhealthy relationship continues to this day. The statistics and problems cited above attest to the unhealthy nature of the entire framework under which we have been operating. For purposes of explanation, I can divide our history into four periods, each characterized by a certain sociological "environment":

A. Pre-colonial - the period of time prior to significant contact with and control by non-Indian societies, characterized by cultural coherence and integrity.

BEST COPY AVAILABLE

B. Early colonial - the period of time in which the Navajos came under the control of non-Indian society, characterized by external encroachment, inter-cultural conflict, tribal defeat, banishment, land expropriation, and confinement on federal reservations.

C. Present colonial - the period of time spanning about the last 100 years, characterized by "benevolent paternalism" on the part of the Government and by a protracted condition of chronic dependency in Indian communities, reflected in a wide range of indicators of socioeconomic breakdown.

D. Post-colonial - the period of time yet to come, characterized by individual, family, and community independence, self-reliance, self-governance, dignity, human welfare, strength, access to resources and opportunities for development, freedom to develop and to control one's own destiny, and full participation in and contribution to world society.

This fourth "environment" described above, that is, the "post-colonial" independent period, represents in general terms our goal . . . our vision. It makes sense to have a vision of how things ought to be, in order to give direction and definition to what we are doing today.

BEST COPY AVAILABLE

And in order to get "there" from "here", we have to change the game; i.e., we have to begin to change the framework within which we operate. A coherent Transition Plan is needed, operating according to a new set of rules and assumptions, because the old assumptions and relationships simply do not work in the final analysis . . . and cannot work, since they do not foster individual, family, or community self-reliance, genuine participation in development, or social cohesion. Policies of development and inter-governmental relationships must assume a new sociological environment, must work toward establishing a new environment for self-directed development, rather than attempting to seek meaningful change and development within the present system of relationships.

Many of us in progressive Indian communities felt very encouraged by the passage and early years of implementation of Public Law 93-638, the Indian Self-Determination and Educational Assistance Act of 1975, because the rhetoric and promises seemed to be leading in the right direction. However, in the past five years or so, we have become extremely disappointed by the lack of genuineness and effectiveness of "638", and have become deluged and boxed in by torrents of governmental constraints, intrusions, regulations, and procedures.

BEST COPY AVAILABLE

So "638" showed some promise, but it has been forced to operate within the wrong framework, the wrong environment, i.e., the stage of colonial control indicated as item "C" above. It embodies the frustrating hypocrisy of holding out the hope and intent of self-determination, while regulating agencies undermine that very objective every step of the way.

Instead of attaining true self-determination, we continued to confront a general governmental and societal orientation toward paternalistic control. This mistrustful, dependency-fostering attitude has become more "benevolent" and subtle in the past twenty years than, of course, the genocidal strategies of the mid-nineteenth century. But the results are still depressing, and local initiative, cohesion, and development are sadly lacking. Further, bureaucracies such as the Bureau of Indian Affairs can be seen to be self-perpetuating, with its very existence based on the continuation of the dependency relationship.

Many Indian communities essentially lack solvency and integrity for the very reason that they lack control over resources and control over their own destinies. It is difficult to achieve solvency and integrity in the absence of ownership, tax base, and autonomy.

BEST COPY AVAILABLE

Money and other resources are important elements in development, but are secondary to the main issue, which calls for the full restoration of human rights, Indian community self-governance, and freedom to develop.

Solutions, therefore, must reconcile two apparently conflicting requirements: the need for Indian communities to be free to direct and control their destinies; and the need for external resources and technical assistance essential for development in the modern world. Below, we propose a few possible directions.

1. Encourage each Indian community to develop comprehensive 10-Year Development Plans leading to the Year 2000. Full technical assistance should be available from the Federal Government, especially in FY 1987, 1988, and 1989, and the Government will subsidize the approved Plan each year during the period FY 1990 to FY 1999. Some communities just getting started will start small, increasing their funding levels for a few years, and then gradually reducing funding in the latter years of the period. Other communities with a history of funded development would begin with an amount equivalent to their total assistance in FY 86 plus possible increments for special unmet needs, with gradual reductions down to a relatively nominal level in the Year 2000. The local community will have full discretion over

BEST COPY AVAILABLE

and responsibility for the prioritizing and allocation of these funds, no strings attached, constrained only by the general law of the land governing financial ethics.

2. Consider the termination of the Bureau of Indian Affairs, passing on to Indian tribes and communities the authority and responsibility for their own development, and using the savings so derived to fund the Development Plans described above.

3. Permit and encourage the total political reorganization of Indian communities - on our own terms, rather than according to the requirements and concepts of the federal bureaucracy.

4. Turn over all Indian reservation-related lands to each tribal community and its citizens, and aggressively consolidate community lands to the highest extent possible. Since the first generation of this new style of development will be very difficult and delicate, certain protections should be assured, so that these newly independent communities will not be taken advantage of by a more aggressive and experienced dominant society.

5. The U.S. Government and each tribal/community authority should be seen as co-equal partners in development. The U.S. Government benefits by being able to demonstrate to the world its sincerity and effectiveness in the restoration of the human rights of its

BEST COPY AVAILABLE

own citizens, plus it will have less of a burden and responsibility for Indian development in the long-run. Indian communities will benefit by having control of their own destinies.

In closing, I would like to express my appreciation to the House Select Committee on Children, Youth, and Families for opening themselves to information and comments from the grassroots, and for seeking to educate the nation regarding the unique needs, challenges, and visions of our People.

126
BEST COPY AVAILABLE

TABLE OF CONTENTS FOR ADDENDA

Addendum I - Map of Ramah Navajo Area

Addendum II - Historical Background Statement

Addendum III - Socioeconomic Statistics

Addendum IV - Identification of Need Youth and Family Development

Addendum V - Ramah Navajo Community Economic Development Summary

Addendum VI - Pine Hill School Transportation and its impact on Ramah Navajo Community

Addendum VII - Adult, Community, and Non-formal Education Needs Statement

Addendum VIII- Statement by Katie Henio, Ramah Navajo Elder

Addendum IX - Health Services

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 1

Map of Ramah Navajo Area

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 2

Historical Background Statement

61-183 0 - 86 - 5

THE RAMAH NAVAJO COMMUNITY

HISTORICAL BACKGROUND STATEMENT

INTRODUCTION

This historical background statement has been prepared to provide information and perspective for the development of plans and programs aimed at reducing the incidence of crime and delinquency in the Ramah Navajo Community. Any attempt to assess the needs, the problems, the goals, the potentials, and the unique character of the Ramah Navajo Community must take into account the historical context - both in terms of past events and of present circumstances.

The present geographic location of the Ramah Navajo Community is the result, not of choice on the part of the Navajos, but of disruption, encroachment, and exploitation on the part of the U.S. Government, the railroad, and the Anglo settlers. The weapons of bureaucracy, Acts of Congress, and westward expansion ruthlessly evicted the Ramah Navajo from the choicest land in the Ramah area and eventually forced them to settle mostly within the boundaries of the Ramah Navajo Reservation, located to the southeast of the present town of Ramah, on relatively rugged, dry, and unproductive land, with relatively no property rights. In short, the history of the Ramah Navajos can be portrayed as a series of blows and tragedies from which they are just now beginning to recover.

SETTLEMENT AND RESETTLEMENT

According to both oral and written histories of the area, Navajos were living in the Ramah area prior to the tragic "Long Walk" period of the late 1860's. Navajo families are known to have lived as far north as the McGaffey mountains and as far south as Apache Creek, Quemado, and other areas south of the present-day Ramah Navajo Reservation. In 1868, troops of the U.S. Government attacked the local settlements, killing many of the people, and capturing many more to send to the prison stockade of Ft. Sumner, in eastern New Mexico. During the Ft. Sumner imprisonment, a treaty was signed between the Navajos and the U.S. Government, which provided that the Navajos could not return to their former free and widespread grazing lands. Instead, they were to be confined to the new Navajo Reservation, and their movement - and, therefore, way of life - was restricted. A few of the families originally from the Ramah area remembered the abundance of water, arable land, and wild fruits growing in the area near the McGaffey mountains, north of present-day Ramah, and they were able to re-settle there. Other families eventually drifted into the same area from such places as Tohatchi and the Chuska mountains further to the north. Finally, most of these families settled in the area just

BEST COPY AVAILABLE

north of present-day Ramah town, where there were both a spring and a river. These families built an earth dam there, which began to form a lake.

LAND ACQUISITION AND FORCED RESETTLEMENT

During this time, the only other settlers in the Ramah area were of Spanish and Mexican descent, who lived a somewhat similar life-style to the Navajos. There were some conflicts between these groups and some raiding of livestock, and so forth, but things were relatively stable. In the mid-1870's, Anglo settlers, mostly Mormons, began to move into the area. At first, so the local oral histories indicate, these newcomers were friendly and neighborly, but soon they were working to acquire the land that the Navajos had already settled on. The Navajos didn't resist, for fear of reprisals reminiscent of the Long Walk period. Acts of Congress added strength to this encroachment. The Enabling Act of 1866 allowed the railroad to acquire land forty (later fifty) miles either side of its tracks, which included the best land in the northern part of the Ramah area. The Homestead Act of the 1880's encouraged settlement throughout the "American West" and provided land to Anglos which by right was Navajo land. The Navajos living in the Ramah area were never aware of these laws during the first years of their enforcement. When they did become aware of what was happening to their land, they still did not have the educational background nor familiarity with Anglo law to compete for the land which was being deeded to a flurry of Anglo applicants. The result of all this was that the Ramah Navajos were progressively pushed southeastward toward relatively infertile and inhospitable land, where they now, for the most part, reside.

These discouraging years have been summed up in a recent historical study of the Ramah Navajo Community:

> The first phase of Navajo history in the Ramah area was characterized by settlement, initial contacts with Mormon Anglos, land disputes, resettlement, and a general attitude of frustration and defeat. While the Navajos faced many problems in their attempt to wrest a living from the stingy environment (e.g., water shortage, crop failure, insects, and disease), these were secondary to the continuing losses sustained as a result of their many encounters with the exploiting Mormons.*

CONTINUING LAND PROBLEMS

The forced resettlement of the Navajos onto restricted lands brought great

---

* Blanchard, Kendall. The Ramah Navajos: A Growing Sense of Community in in Historical Perspective. Navajo Historical Publications, The Research Section, Navajo Parks and Recreation, The Navajo Tribe. 1971. p. 25.

BEST COPY AVAILABLE

pressure to bear upon them as did the continuing confusion brought about by their interactions with the Anglo settlers and with the U.S. Government. The Allotment Act of 1887 allowed individual Indians to receive a "trust patent" for a maximum of 160 acres of grazing land. These were to expire after twenty-five years, at which time the allottee could receive full title to the land, unless the U.S. President chose to extend the trust period; these patents have been extended every year since then by Executive Order. Only one Navajo ever applied for allotted land during the first thirty years the law was in effect, but from 1920 to 1940 most Navajo families got 160-acre allotments. The problem was that these allotments were interspersed between privately-owned land, state lands, and public domain, which increased the Navajos' confusion. These allotments, plus the purchase by the Navajo Tribe in 1929 of 18 sections of land south of Ramah, were about as much land as the Ramah Navajos got.

The forced displacement of the Ramah Navajos was a staggering social and economic setback for the people. The new land was not fertile enough to sustain the same level of farming as the Navajos had previously enjoyed; there were less plentiful grazing lands for the livestock; and families were again separated and dispersed. Later on, the Taylor Grazing Act of 1934 was to set a limit on the number of livestock per area and capacity of land, which resulted in livestock reduction for most families. The quotas established in the 1930's are, for the most part, still applicable today, which means that there is no apparent way for most families to increase their wealth through livestock herding and management, which is integral to the life and identity of the people. To complete this cycle of regression, nothing was offered to replace this livelihood, so the net result was that the fortunes of the local community were again reversed.

Between 1930 and 1940, the U.S. Government leased land in the Ramah area on behalf of the Ramah Navajos. However, local ranchers and settlers petitioned to have this lease annulled and to have the land opened up for sale. The Government concurred with this petition, and there were soon many land sales in the Ramah area. This time it did not take long for the Ramah Navajos to become aware of what was going on. They appealed to the Albuquerque Area Office of the BIA to find a way to secure land for the Ramah Navajos. Since there were sufficient funds in the Treasury under the name of two Pueblo tribes, these funds were used to purchase land in the Ramah area. For about eight years, the Navajo Tribe leased this land on behalf of the Ramah Navajos and then purchased it. According to the Tribal Councilman for the Ramah Navajo Community, who was

BEST COPY AVAILABLE

intimately involved more than thirty years ago in these transactions, the land was to be solely for the use of the Ramah Navajos. However, in the early 1960's, the Navajo Tribal administration of Raymond Naakai determined that all land purchased by the Navajo Tribe in the past would be governed only by the Tribe - a ruling which included the land purchased in Ramah. Even up to the present time, this has presented difficulties for the Ramah Navajo Community in terms of developing and using Tribal land.

Restrictions, legalities, and past injustices continue to make the land problem a hindrance to the growth of the local community. Due to the land sales of the past century, the Ramah area is "checkerboarded" by private, state, public, Chapter, and Tribal land-holdings. Negotiations with the various parties concerned over access and road easement are long and sometimes totally futile with regard to bringing in utility lines and constructing new roads. Further, there are 21 sections of land in the southern part of the Reservation which are held by the BIA on behalf of the Ramah Navajo Community, but only for grazing purposes; therefore, no development or improvement can take place on that land. Finally, there is a large portion of land held and governed by the Navajo Tribe, which is used by the Ramah Navajos, but any development of which must have the approval of the Tribal bureaucracy.

An additional land problem for the local people is that there is no more land which can be allotted to individuals or families. With the increase in the local population, that means that each new heir or relative gets an increasingly small parcel of land. This has already begun to create stress within extended family groups, and the future situation does not look bright. Again, there is a feeling of being trapped: no more land, fewer livestock, drought conditions, and more people to feed and provide for.

INCONSISTENT SERVICES

Prior to 1927, there was practically no attention given to the well-being of the displaced Ramah Navajos by governmental agencies, including the Bureau of Indian Affairs (BIA). According to anthropologist Clyde Kluckhohn: "The picture seems to have been that of leaving the Ramah Navajo severely alone except for rare incidents when Anglos or Spanish-Americans demanded intervention on land matters or disturbances of law and order."*

* Kluckhohn, Clyde. Quoted in Blanchard. p. 28.

BEST COPY AVAILABLE

In 1927, the Ramah Navajos came under the jurisdiction of the newly-formed Eastern Navajo Agency at Crownpoint, and some attempts were made to serve the Ramah Navajos. Dams, wells, and roads were constructed, and the Taylor Grazing Act of 1934 was implemented. The Ramah Navajos were not always receptive to these things and remained skeptical of the benefit of some of these projects. In particular, the livestock reduction resulting from the Grazing Act was a threat to many customs and values which the people held dear. Further, it felt as though they were trapped, not being able to expand their herds, on the one hand, nor increase their land-holdings, on the other.

Due to the isolation of the Ramah Navajo Community, services by both the Bureau of Indian Affairs and the Navajo Tribe have historically been inconsistent, sporadic, and of poor quality. Local community leaders complain that the Ramah Navajos were dealt many staggering setbacks and were offered almost nothing in return. Further, whenever there was some sort of service provided, the aim was not to enable the local community to become self-supporting and strong as a community. There were many years of unfulfilled promises and actions that were either too little or too late. There was never any long-range planning, and there was very little continuity in terms of the services being provided to the community. The Ramah Navajo Community was shuffled from Agency to Agency, and the progress of the community continued to be stifled. Finally, an Agency was established on the Ramah Navajo Reservation in 1972.

SELF-DETERMINATION

Meanwhile, totally dissatisfied with the services promised by outside Agencies and programs, the Ramah Navajos began working toward self-sufficiency. Public Law 93-638, the Indian Self-Determination Act, provided just the opportunity the community was waiting for. At a meeting of the local Chapter, a School Board was elected. The School Board was soon incorporated, and a plan of action was initiated to secure funds for the establishment of a local school system which would be responsive to the needs of the Ramah people. The result has been the establishment of a multi-million dollar educational operation with a community development component, now in its seventh year. This will undoubtedly have a far-reaching impact on the Ramah Navajo Community.

The Ramah Navajo Chapter is now emerging as a strong and viable political, economic, and unifying force. There is increased educational and economic opportunity for the community's young people, and vigorous local efforts at self-determination and locally-initiated economic development are being sustained and

BEST COPY AVAILABLE

augmented.

However, the present situation and projected conditions for the near future continue to reflect the isolation, neglect, exploitation, and forced displacement of the past. In many ways the local community is still insufficiently equipped to effectively deal with the myriad changes and influences confronting it. Communications systems are indadequate to serve such a widely-dispersed population, and the community does not not yet have a strong economic base. There are still few recreational and vocational opportunities for the local people - young or old, and alcohol abuse continues to undermine the growth and well-being of the community.

Due to the severe influences of the past and the rigorous and challenging conditions of the present, special attention will continue to be required in order to reverse present problems and to ensure the progress into the future of programs which are just now beginning to make up for a century of tragedy and neglect and to have an impact on the quality of life of the people of the Ramah Navajo Community.

—jgk, 1/25/78

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 3

Socioeconomic Statistics

TABLE I
SOCIOECONOMIC STATISTICS, RAMAH NAVAJO COMMUNITY

1. Labor Force Data

a. Indian Population, Ramah Navajo Reservation	2,280
b. Population 16 years of age or older	1,649
c. Potential, Able-Bodied Work Force	1,442
d. Employed	487
e. Unemployed	955
*Those seeking work 782 (81.9%)	
f. Unemployment Rate	66%

SOURCE: Labor Force Report, Ramah Navajo Agency, Bureau of Indian Affairs, 1985.

2. Combined Annual Family Income 1980

Income	# of Households	% of Total
Less than $5,000	185	54%
5,001 - 10,000	64	18
10,001 - 15,000	43	13
15,001 - 20,000	27	8
20,001 - 30,000	13	4
$30,001 - over	10	3
	342 (79% of households in Ramah)	100%

SOURCE: 1981 Ramah Navajo Community's Economic Development Needs Assessment Survey.

3. Sociological Data

a. Number of Households	732
b. Number of Families on the General	
% of Families 34.7%	
# of Individuals . . . 394	

SOURCE: Ramah Navajo School Board Department of Social Services.

BEST COPY AVAILABLE

TABLE I
SOCIOECONOMIC STATISTICS, RAMAH NAVAJO COMMUNITY, 9/85
Page 2 of 2

4. Education Data

	#	%		
a. Number of community members with Master's Degree plus	5	0.3%		
b. Master's degree only	5	0.3%		
c. Bachelor's / 4-yr college degree	18	1%		
d. Associate / 2-yr college degree or Vocational Certification	29	1.7%		
e. Present enrollment in 4-yr college program	26	1.5%		
f. Present enrollment in 2-yr college program	41	2.3%		
g. High School Diploma, not enrolled in postsecondary	176	10.1%		
SUB-TOTAL - High School Education plus			300	17.2%
h. Present enrollment in High School	179	10.2%		
i. 7th to 11th grade education and/or reading level	183	10.5%		
SUB-TOTAL - Education 7th grade and above			662	37.9%
J. 4th to 6th grade education and/or reading level	537	30.7%		
k. 0 to 3rd grade education and/or reading level	550	31.4%		
SUB-TOTAL - less than 7th grade education			1087	62.1%
TOTAL - including Indians not locally enrolled at Ramah Navajo Agency.	1,749	100%		

SOURCE: Ramah Navajo School Board Offices of Higher Education and Adult Education.

BEST COPY AVAILABLE

RAMAH NAVAJO COMMUNITY

Social Services Statistics

FY 1985

Type of Assistance	Cases	
General Assistance	136	(343 Persons)
Tribal Work Experience Program	10	(29 Persons)
Burial, Burn Out, Miscellaneous	1	1 Person
Child Welfare Assistance	11	11 Persons
Services Only	78	78 Persons
Other Public Assistance		
Aid to Families with Dependent Children	50	
Social Security	171	
Veterans	8	
Supplemental Security Income	97	
Problem Category		
Attempted Suicide	9	
Abuse/Neglect/Abandonment of Children	53	
Single Parent	4	
Substance Abuse	38	
Truancies	15	
Mental Health Counseling	10	
Family Violence	21	
Abandonment of Spouse/Separation	21	
Juvenile Delinquency	5	
Medical Problems	9	
Teenage Pregnancies	4	
Run Aways	8	
Unemployment		
Families with problems related to unemployment	134	
Individuals impacted by unemployment, as related to social problems	590	
Educational Level/Skill Level Deficiency	113	
Divorce	6	
School Behavior Problems	21	

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 4

Identification of Need
Youth and Family Development

IDENTIFICATION OF NEED

1. Demographics

The Ramah Navajo Community is a remote, rural Reservation community in west-central New Mexico. The community is geographically separate from the contiguous main Navajo Reservation (some 40 miles from the nearest edge), but still constitutes a Chapter of the Navajo Tribe. It is more than 60 miles southwest of Grants and about the same distance woutheast of Gallup, the two colsest cities. Ramah Navajo families reside in widely-scattered dwelling clusters, and the Reservation has no villages, retail services, or businesses of its own. The dominant forms of economic activity in the community, outside of federally-funded jobs for a minority of the work force, are animal husbandry and limited-scale dry-farming.

The community's isolation has made it relatively autonomous and independent of the Navajo Tribal government in many respects. The people strongly identify themselves as Ramah Navajos.

The Ramah Indian Reservation is "checkerboarded" into seven different categories of land ownership as a result of historical processes through which the Navajos were progressively forced into a position of subjugation and disadvantage. Much of the Reservation is unsuitable for productive agriculture, and even current development efforts are often hindered by the complexity of land status.

Population figures for the Ramah Navajo Community have ranged between about 1,800 and 2,500, depending on which source one accepts as authoritative. Current projections for 1986 by the Department of Social Services are around 2,600, based on existing census and other data on file, and taking into account the near-reservation Navajos who are eligible for social services (see Appendix). Although recent statistics from the Ramah Navajo Comprehensive Economic Development Plan (1983) show the size of each nuclear family unit to be about 4.4, the actual size of the family cluster, when considering extended family, is probably closer to 8 or 9, according to Social Services Department estimates (see Appendix).

The Ramah Navajo population is extremely young in comparison with the national average, with nearly half (46%) of the population under the age of 24 (see Appendix). According to the Comprehensive Economic Development Plan:

> "There are several implications of a youthful population for the development of an economy.
>
> 1. The dependency ratio is unusually high. That is, the productive 'working age' population must bear a greater burden of the dependent children and elderly persons.
> 2. The relatively high proportion of young people

BEST COPY AVAILABLE

places strains on alredy scarce resources. It is usually difficult for a community to develop the necessary infrastructure at a rate consistent with the demands of the young population.

3. The scarcity of resources and the limitations of economic opportunities often causes outmigration of college-age persons and young families."

The populace is undereducated, as for many years there were no adequate educational institutions available to Ramah Navajos. the Pine Hill School was opened in 1975, and it is only since then that an adequate elementary and secondary education has been available to the children (see Appendix).

There is little paid employment available to Ramah Community residents. The unemployment rate extrapolated from the BIA Labor Force Report for 1983 was 69.3%. At any given time in the course of the year, the actual rate may vary from about 60% to 80%.

The local economy is heavily dependent on infusions of federal funds; there is little self-sufficient economic activity on the Reservation and, consequently, few employment opportunities (see Appendix).

While most families have some non-monetary or non-market income in the form of sheep or cattle or homecrafts, it remains obvious that by national standard, the average family is impoverished. Housing is gradually being improved, but most homes are still substandard and overcrowede; most homes still do not have running water, plumbing, electricity, or telephone. Firewood is the primary fuel source. The many miles of roads the people must travel to get supplies or attend school "...are unimproved and not maintained on a regular basis. During the winter months and wet season, all of the (many) dirt roads often become impassable because of mud or snow." (Comprehensive Economic Development Plan -- see Appendix A)

It is not definetely known what the per capita income is in Ramah Chapter, except that it is extremely low. The Navajo Tribe says the average per capita income for all Navajos is $2,000, compared with $6,120 for New Mexico as a whole in 1980. More than half of Ramah Navajo households had an annual income of less than $5,000. Two-thirds of households receive some type of public assistance in the form of Food Stamps, Aid to Families with Dependent Children, Social Security, Supplemental Security Income, Veteran's Benefits, General Assistance, Tribal Benefits, etc. (see Appendix).

While these geographic, demographic, and economic conditions do not in themselves create the social problems which this proposal hopes to address, they indicate the degree to which family and community life has been disrupted and the degree to which they are in need of development and integration. It is from

BEST COPY AVAILABLE

a disintegrated, demoralized community that the problems seen among youth arise.

2. The Problem and its Symptoms

An increasing number of Ramah Navajo youth are having difficulty negotiating the range of challenges presented to them in the contexts of family, school, and community. At home they are having difficulty communicating with their parents and other family members, and are feeling increasingly alienated from the values, patterns, structures, and requirements of the family. In school, many of the youth are not motivated in their schoolwork and are not achieving acceptable levels of academic preparation. They are likewise increasingly alienated from the values, patterns, structures and requirements of the school. Finally, the youth do not play a meaningful role in the community as a whole, and they are not developing a healthy sense of responsibility -- to self, to others, or to the community.

The common thread running though the various problems and crises involving our youth is CHRONIC DEPENDENCY: the inability to be responsible for one's own behavior, well-being, and support, characterized by inadequate skill development, lack of attitudes which lead to capabilities, and lack of understanding of one's place in the world in relation to other people and situations. (NOTE: This and other concepts throughout the proposal have been adapted from Glenn and Warner, Developing Capable Young People, 1982) As a consequence of the broader disintegration of culture (discussed in more depth below), the following aspects of disintegration further illustrate the range of problems related to this dependency.

Community Disintegration. One element of the overall cultural disintegration taking place is at the community level. This is characterized by: the erosion of inter-family cooperation; the loss of genuine community self-governance (since the community is dependent on federal support and has little actual control over its own resources); the lack of effective forums and processes for community problem-solving and genuine citizen participation; divisive political processes; inter-familial jealousies and conflicts; and the lack of a solid, productive, wealth-generating local economy.

Family Disintegration. At the level of the family the effects of cultural disintegration have been felt very dramatically. This disintegration is characterized by: the gradual erosion of the integrity, security, and role of the extended family; the ever-increasing communication gap between generations, especialy between parents and their children; the ever-quickening change from a rural, self-subsistent life-style to socioeconomically-dependent and/or urban/money-based lifestyles; the corresponding decrease in the genuine sharing by the young in family responsibilities and chores; the increasing incidence of family break-up and single-parent families; the increasing incidence of young pregnancies in the absence of the preparation by young couples for mature rela-

BEST COPY AVAILABLE

tionships and self-reliant family life; the increasing incidence of alcohol abuse by parents and the consequent neglect of children; the increasing incidence of the abuse of intoxicating substances by youth; and the lack of parenting know-how and the loss of parents' control over their children's behavior and development. The relationships between parents and youth are weakening rapidly: the parents often complain that their children do not listen to them and do no obey; they bemoan the children's irresponsibility and preoccupation with unproductive pasttimes; and they feel at a disadvantage with regard to the children's school experience, as many of the parents do not read, write, or speak English, and/or do not know how to support their children's education. Authoritarian and traditional methods of discipline no longer seem to work. The youth often complain that their parents do not understand them and are out-of-step with the times. The destructive behavior displayed with increasing frequency by many of the youth is an expression of the discontinuity and alienation they feel.

Individual Disintegration. The consequences of cultural disintegration ultimately impact the individual, in whom the pain, dysfunction, and tragedy are most directly registered. The disintegration of the person is characterized by: increasingly high incidences of alcoholism and of the abuse of intoxicating substances; unfulfilling social and martial relationships; increasing incidence of suicide; irresponsible and anti-social behavior by the young, both in and out of school; lack of a coherent personal system of values and beliefs; lack of purpose and meaning in life, and the absence of personal goals and aspirations; lack of self-confidence in social and cross-cultural situations; the breakdown of self-respect and interpersonal respect; lack of skills and attitudes needed for self-supporting economic activity; personal confusion and the lack of a "sense of place" in this changing world; inadequate educational preparation for successful and/or competetive participation in the non-Reservation society and economy; a decreased sense of genuine responsibility and significance, especially by the young, in the life of the family and the community; and an increased tendency to engage immoderately in pleasure-seeking diversions and preoccupations.

3. SOME MAJOR CAUSES OF THE PROBLEM

Although there are unique historical, cultural, and socioeconomic factors impinging upon the problems of youth in the Ramah Navajo Community, there are nevertheless many factors which this community shares in common with the society at large. These common factors will be discussed first.

Massive changes have taken place in society in the past half-century, characterized by rapid technological development and urbanization. Accompanying these changes has been a dramatic change in family lifestyle:

* from rural, low-technology lifestyles to urban, high-technology ones;

BEST COPY AVAILABLE

* from high levels of interaction within the family to extremely low levels;
* from low rates of change, information flow, and inter-cultural contact to high ones;
* from homogeneous family and community values and high predictability in life to heterogeneous values and low predictability regarding life's demands;
* from a limited range of role models reflecting high consonance with family morals/values to a wide range of role models reflecting varying degrees of dissonance with family values;
* from a high degree of inter-generational association and continuity (a dominant extended family) to a low degree (with a diminishing role for the extended family). (Adapted from Glenn and Warner)

Among the consequences of these transitions are the following deficits when it comes to guidance of and support for the young:

- losses of access to viable role models;
- losses of opportunities to contribute to family;
- losses of natural ways to develop self-esteem;
- losses of opportunities to develop problem-solving skills;
- losses of experiences which develop an identity with things greater than self;
- losses of experiences which teach the natural and logical consequences of personal decisions and actions. (Adapted from Glenn and Warner)

Although the degrees, rates, and specific manifestations of such transitions and consequences are unique for the Ramah Navajo community, as compared with other communities both Indian and non-Indian, both rural and urban, nevertheless the fundamental characteristics of chronic dependency remain the same. Local/cultural factors related to this dependency are described below.

As is true of the Navajo People in general, the way of life as traditionally practiced in the Ramah Navajo Community has been subjected to direct attack, indirect undermining, and overwhelming challenges imposed by the clash of indigenous culture with the now-dominant urban/industrial culture. This clash has resulted in the destruction of the people's economy, the alteration of their community and family life, the reduction of their land base, and the erosion and near-elimination of their independence. Within this context, social programs offered by the federal government to address various year-to-year material needs of the Ramah Navajo People have often built patterns of increased dependency, loss of motivation, and passivity. Educational programs have often exacerbated the cross-cultural clash, hastened inter-generational discontinuity, and produced a confusion of values and relationships. Consequently, there has been a breakdown (at all levels: the individual; the family; the community; and the culture) in self-confidence and self-esteem, in self-determination and self-direction, in the strength and integrity of social relationships, and in economic productivity, reciprocity, and self-reliance.

BEST COPY AVAILABLE

The problem, then, is one of family disintegration: youth problems are symptoms of the stress associated with this disintegration. Additionally, the disintegration of the community manifests itself in a state of deficiency in cultural resources, economic foundations, and employment opportunities. One senses the feeling of powerlessness of traditional culture in the face of the challenges presented by the broader, largely-materialistic culture and by the sweep of societal and technological change. The consequence is that many Ramah Navajo youth exist in an environment of chronic dependency, despair, and lack of opportunity, are torn between conflicting values and loyalties, and are often caught in "values limbo".

The Ramah Navajo Community has experienced a transition from a rural/self-subsistent lifestyle to an urban and/or socioeconomically-dependent one with its accompanying "inflation of expectation". Yet, while new images and concepts dominate the younger generation, and while the school experience broadens horizons and the range of choices, the local socioeconomic realtiy cannot accommodate or satisfy the new expectations. This situation, unique perhaps to impoverished/minority communities, exacerbates frustrations and heightens the stress on the individual and the family.

Some of the youth have become subject to the more extreme consequences of cultural disintegration, and their behaviors have become such as to warrant special attention. The course of last resort is placement in a Youth Treatment facility, and in the past such placements have been to locations more than one hundred miles from the community. Last year, a Therapeutic Group Home was constructed in the community, on Pine Hill campus. Such a local group home was intended to provide shelter and intensive residential counseling for such youth, while at the same time addressing the needs of the family, with the aim of achieving re-integration of the youth into the family. Unfortunately, appropriate and/or adequate Federal funding sources for such a comprehensive youth services project were/are not available. Therefore, the Ramah Navajo School Board has designed a multi-services approach in order to meet the diverse kinds and levels of need of our youth through multiple funding source support.

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 5

Ramah Navajo Community
Economic Development Summary

Ramah Navajo School Board, Inc.

Ramah Navajo Community Economic Development Summary

May 1985

BACKGROUND AND INTRODUCTION

While the average American family groans as unemployment rates "leap" over 7%, and the Black community complains of unemployment in its ranks approaching 20%, American Indian communities struggle under the burden of unemployment rates from 35% (in the most economically "developed" communities) to almost 80%. The Navajo Tribe's unemployment rate has remained consistently in excess of 60%, even during the mid- and late-1970's, when federal support of Indian programs was at its peak. The Ramah Navajo Community's figures follow suit with those of the Tribe; labor force reports prepared by the local Agency of the Bureau of Indian Affairs attest to unemployment rates consistently in the 60% to 70% range.

Accompanying these distressing unemployment figures are a wide range of (a) contributing factors, and (b) social consequences in the community. Historical causes were summarized in a document prepared by the Criminal Justice Research Committee appointed by the Ramah Navajo Agency in 1977 and 1978, "The Ramah Navajo Community: Historical Background Statement". The document emphasizes the socio-economic disruption caused by the intrusion of an insensitive outside culture into the Ramah area, and the "one-down" position into which the Ramah Navajos were placed before and following the U.S. government's treaty with the Navajo Tribe in 1868. It also describes the inconsistency and inadequacy of official services to the community from that time until the 1960's, culminating in the community's self-determined effort to take its development into its own hands, symbolized and implemented by the establishment of the Ramah Navajo School Board, Inc., in 1970.

This historical document accompanied a report, inclusive of community needs analyses and action plans, published in 1978, in which the dominant criminal justice concerns and systematic solutions were described. This was to be the basis of future proposals to be developed by the Agency and the Community for the purpose of securing funds with which to implement the solutions outlined. Follow-up and proposal development based on this report were not systematic (although numerous proposals have addressed related problems and needs), and the document remains descriptive of existing criminal justice concerns, by the far the most dominant of which was determined to be Alcohol Abuse.

Other contributing factors toward and social consequences of

BEST COPY AVAILABLE

G. To establish community and/or privately-owned economic enterprises and activities in each primary "survival" category: Food and Land; Clothing; Shelter; Transportation; and Homemaking.
H. To establish utilities services in every community unit by overcoming present obstacles to utility development.
I. To train and develop local community members in business management and in the various trades involved in the economic development plan.
J. To establish an alternative means of financially supporting Ramah Navajo School Board operations through the development of affiliated economic activities.

Although this plan was, and has been, useful for purposes of reference (particularly during proposal development), it was never actually operationalized in a systematic or structured fashion. In early 1981, the Division of Community Research and Development of RNSB established a Community Planning Office and hired two professional staff, ostensibly to spearhead and implement economic development initiatives. The above-referenced Preliminary Economic Development Plan was conveyed to that office for follow-through. Although the Plan may have been used as a starting point and for subsequent reference, it was not placed in the foreground of planning activity.

LOCAL INITIATIVES SUPPORT CORPORATION (LISC)

The Community Planning Office performed two major activities: (a) the development of a grant proposal and the successful securing of funds from the Local Initiatives Support Corporation (LISC); and (b) the design and implementation of a Community Economic Needs Survey.

In collaboration with the Center for Community Change (CCC), the community planners put together a project application which proposed to accomplish four main purposes:

1. To analyze the local economy. [NOTE: this was altered later to read: To evaluate the economic survey and to derive goals and objectives from the results."]
2. To set economic development goals and priorities. [NOTE: later changed to: "To develop a Comprehensive Economic Development Plan."]
3. To construct a framework for evaluating economic development opportunities. [NOTE: this purpose was later deleted from the project.]
4. To design an institutional vehicle [later changed to "model"] for developing, owning, and managing economic ventures.
5. To analyze and pursue specific retail development.

Soon after the grant was received, there was an abrupt turnover in planning personnel, and the project never "hit stride". Several project period extensions, as well as scope modifications, were requested and

BEST COPY AVAILABLE

economic under-development have been discussed and documented in dozens of proposals and reports prepared by the Community, primarily through the offices of the Ramah Navajo School Board since its inception fifteen years ago. A majority of these applications have been funded by the federal government, addressing various educational, social, and economic needs. The wide range of projects was encouraged by the School Board's broad-based and holistic philosophy, which centers around the Child but which takes into account all of the various aspects of community life impinging on the Child's development, such as housing, sanitation, family well-being, indigenous language and culture, and so on. The Board's mission has been, not only to provide a good education for the Community's children, but also to improve the quality of life of each family and to ensure that there is a viable future - both within and outside the Community - in which the children can place their hopes and toward which they can strive. Inevitably, the Board would at some point need to address directly the problem of economic development.

Although a few projects had been attempted in the early and mid-1970's, including the School Farm which is still operational today, "push came to shove" in 1980 when School Board staff began preparing a funding proposal for a Vocational Education Project, the regulations of which required that the project be directly tied to the Community's "Economic Development Plan". Attempts to uncover such a Plan were futile, so a Task Force was convened to address such a Plan in its general outlines and dimensions.

PRELIMINARY ECONOMIC PLANS

In November, 1980, the School Board passed a resolution approving a "Preliminary Economic Development Plan," in which general 10-year goals and a follow-through plan of action were outlined. The goals were as follows:

A. To develop a local, community-generated economic base.
B. To reduce unemployment from 65% to 25%, implying that at least three-quarters of the local labor force will have meaningful, self-sustaining employment.
C. To expand the local job market by developing new employment opportunities.
D. To increase family self-reliance by increasing food and livestock productivity, developing internal and external markets for agricultural produce, and implementing intermediate energy-technologies.
E. To establish and incorporate an Economic Development Council in the Ramah Navajo Community, which will coordinate, implement, and develop funding for economic development plans.
F. To reverse the situation in which money earned in the community is spent outside the community, i.e., to keep money within the community as a capital foundation for self-reliance and further development.

BEST COPY AVAILABLE

authorized, and by 1983 several "pieces to the puzzle" had been developed, but without system, coordination, or ultimate implementation. The Board's new planning office attempted to pick up those pieces and to weave them into a coherent whole, at least for purposes of reporting back to LISC the project accomplishments and for establishing an understandable plateau of accomplishment from which further development could be launched. Although RNSB did not literally fulfill the terms of the original grant, a number of results were, in fact, achieved, to the satisfaction of the granting agency, LISC. Most notable among the accomplishments were: (a) the completion of the instrument and the data gathering for the Community Economic Needs Assessment; (b) the publication of "Ramah Navajo Community Comprehensive Economic Development Plan", written by consultant David Hanna; and (c) the development of plans, in various stages of completion, for more than a dozen potential economic/business projects, among them:

1. Local Store Retail Joint Venture;
2. Native Plants and Seeds Project;
3. Utilities/Water Systems Development;
4. Graphics Center Business Project;
5. Construction Enterprise (including Road Improvement; Sand/Gravel/-Cinder; and Native Building Materials);
6. Coal Resource Development;
7. Arts & Crafts/Tourism Business;
8. Laundromat/Service Station/Mini-mall Business;
9. Greenhouse/Seedling Project;
10. Alfalfa/Irrigation/Feed-lot Business;
11. Radio Station Expansion/Self-Support Project;
12. Campus Cafe Business;
13. Early Childhood Materials Business;

Based on demographic and economic data collected, and in collaboration with RNSB planners, the Comprehensive Economic Development Plan identified potential economic projects in two main categories:

Group A - High Priority/Immediate Follow-up

* CONSTRUCTION ENTERPRISE, in 4 phases:
  - Native Building Materials Operation (Adobe & Dimension-Stone, Tile, etc.)
  - Sand, Gravel, and Cinder Operation
  - Community-Based Road Improvement Project
  - Construction Company

* TOURISM/TRAVEL ENTERPRISE, including Arts & Crafts sales

* SHOPPING COMPLEX, including:

  - Laundromat

BEST COPY AVAILABLE

- Grocery Store
- Feed Store/Livestock Supplies
- Service Station & Repair Garage
- Cafe/Restaurant

* SOIL AND WATER CONSERVATION DISTRICT

* CREDIT UNION

* GRAPHICS/PRINTING ENTERPRISE

* GAS, OIL, AND GEOTHERMAL EXPLORATION AND UTILIZATION

Group B - Lower Priority/Further Study as Possible

* Native Plants and Seeds Enterprise

* Livestock Grazing Improvement

* Government Office Complex

* Recreation Centers on 5 Community Sites

* Resort Enterprise

Although termed a "Development Plan", the "Hanna Report" lacked detailed operational plans, and much remained to be done to set forth actual objectives, strategies, tasks, schedules, deadlines, etc. Implementation of the plan has occurred in various ways, though not as systematically as may have been optimal.

IMPLEMENTATIONS

Due to the diversity of piecemeal funding sources available for economic development planning and activity, the above-described plans and priorities have not always been addressed systematically. In particular, most of the funding available has been primarily limited by regulation to planning activities, as opposed to implementation. There has been no funding for (a) capital investment in commercial development, or (b) administration and management of actual business projects.

A number of community development priorities and projects have been accomplished through these limited funding sources, with BIA Component "2090" [Community Services-General] providing most of the funds. Among the achievements are the following:

1. Twenty-one (21) sections of BLM land in the south portion of the Ramah Reservation were secured through effective research, planning, and inter-agency negotiation.

BEST COPY AVAILABLE

2. Planning for remote-site and clustered water system services was successfully done, in collaboration with the Indian Health Service.
3. Planning and application development was successfully done to secure Housing & Urban Development (HUD) Community Development Block Grants (CDBG) for housing in the community.
4. Planning and implementation of the extension of telephone and electrical lines, with Universal Telephone and Continental Divide Electric Co-op respectively, were successfully completed.
5. Planning for and establishing the Ramah Navajo Utility Commission were successfully accomplished.
6. Planning for and installation of solar electrification and heating projects at remote homesites were accomplished in collaboration with the Indian Health Service (IHS) and the Navajo Tribe's Chapter Development office.
7. Effective planning and liaison activities with the Midwest Community Action Program (CAP) were carried out with regard to energy assistance funds and projects for the community.
8. Planning for the expansion and ultimate self-sufficiency of the KTDB-FM community radio station were successfully carried out, resulting in the securing of a major grant from the National Telecommunications and Information Agency (NTIA) to upgrade the equipment and capacity of the radio station and to extend its services into the Eastern and Northern Agencies of the Navajo Reservation. Other planning efforts to increase KTDB's self-sufficiency have also been carried out.
9. Planning and proposal development for numerous Chapter Development projects were successfully carried out, resulting in such projects as Greenhouse remodeling for the School Farm and other local initiatives.
10. Activities in livestock improvement and range management development were carried out in collaboration with the Pine Hill Schools' vocational projects.
11. Demonstration gardening and animal care activities were undertaken at the Community/School Farm.
12. Effective planning for agricultural development and community self-sufficiency was carried out, resulting in a major proposal under the Administration for Native Americans, which was not funded due to jurisdictional issues involving the Navajo Tribe, but which served as a document from which numerous subsequent projects and proposals were developed, including a major three-year grant for a Rural Technology vocational education project received from the US Department of Education.
13. Liaison activities with Cibola County were effectively maintained with respect to economic planning and development.
14. Liaison work and assistance to the Futures for Children projects for the community were carried out.
15. The Free Book program was introduced into the community and implemented by the Community Planning office.

BEST COPY AVAILABLE

In the past year, several low-key but very practical and highly effective activities have been accomplished in service to the Community Services Contract with the Bureau of Indian Affairs, among which are those relating directly to economic development:

1. Planning for and establishment of the Ramah Navajo Weavers Association were accomplished. This involved extensive grass-roots communication and group work, and resulted in the more direct involvement by community members in their own economic development. Some present priorities include the re-introduction into the community of Churro sheep and the organizing of community weavers for purposes of streamlining and improving marketing, cost efficiency, and revenues, etc.
2. Effective community organizing in the way of helping community members via self-help committees to consult among themselves regarding their needs (for instance in the subsidized housing projects at Pine Hill and near Ramah village) has been carried out. Numerous priorities and potential projects have emerged from this process, including fire protection organizing, social/recreational development, landscaping/environmental improvement, etc. Further activities have included the exploration with community members of the potential of establishing "unit community centers" in each of the grazing/demographic units of the community, as well as of establishing a community culture center at which works of art could be displayed and sold in conjunction with a roadside cafe.
3. A roadside rest area arts & crafts business has been planned and worked on.

Most of these economic and community development activities are of the sort that take a long time to germinate and develop into self-sustaining and successful ventures. Recent planning efforts have been more focused on simple, singular projects involving local community members, rather than on multiple-concept plans and grandiose projects. It has been recognized that a combination of local initiative and the externally-derived development of seed capital are needed in order to transform the local economic picture.

With respect to the higher-profile economic projects, the RNSB administration realized that additional expertise was needed to translate the community's general economic plans into actual economic operations, and it contracted with a Business Development Specialist in the Spring of 1984 to take one or two priority business projects and work them up into professional business plans which could be submitted for major funding from the federal government and/or from the private sector. Two priority projects were identified: (a) a shopping complex; and (b) an arts and crafts enterprise. The consultant undertook a study of RNSB's past economic planning documents, analyzed the economic/-marketing environment of the community, and developed business plans and proposals in these two areas. He then followed up by developing

BEST COPY AVAILABLE

governmental and private support for these projects.

Successful receipt of funds was deterred by bureaucratic restraints within the governmental "system" and by delays in obtaining Chapter approval of the proposals, a step required by the regulations governing the grants. To date, funding has not been forthcoming for those proposals.

An auxiliary assignment for the consultant was to work closely with RNSB planning staff and to provide technical assistance and training in the development of business plans, such that local personnel could continue the business development process independently. This occurred only to a minimal extent. Nevertheless, RNSB planners have acquired some expertise and experience in this area.

Concurrently with the implementation efforts described above, a couple of home-grown projects were attempting to move into the self-supporting business arena: the Tsá'ászi' Graphics Center; and the Native American Materials Development Center (NAMDC). Each of these centers was begun under major federal grants in the 1970's, and their continued existence became dependent on self-supporting kinds of business activity, as federal support of such centers declined dramatically in the early 1980's. The Graphics Center was able to generate impressive gross sales, but operational costs (including the assumption of unfinished projects left hanging by Native American Press, an arm of NAMDC) proved prohibitive, even despite a number of in-kind benefits it maintained by virtue of its association with RNSB. To date, it maintains a fragile status but has survived, though not independently of RNSB programs and services. The Native American Materials Development Center has not had the same fortune and at the present time maintains only minimal activity.

RETROSPECT AND PROSPECT

Economic development in the Ramah Navajo Community presents a formidable challenge. The task is to construct a local, genuine economy practically from scratch, in place of what might be termed a "false economy", i.e., one which is based almost entirely on material support from the federal government. Numerous factors come into play when addressing this need, including:

- Size of labor force and levels of training, education, and experience in kinds of work applicable to a local economy;
- Extent, manufacturability, and marketability of local physical resources;
- The existence or accessibility of capital with which to initiate business ventures;
- The will and energy of the people, and their willingness to regain a central role in creating wealth;
- The influence and relevance of the community's heritage and culture,

BEST COPY AVAILABLE

in comparison with the influence of the outside world;
* The degree to which the families and schools prepare the community's young for proactive, creative, and responsible economic activity.

Efforts have been made in the past decade to directly address the challenge of economic development in the community. The successes of those efforts have been limited, but it is essential to look upon them as building blocks and stages of growth, from which much can be learned, and upon which further developments can be made. Future efforts must depend upon:

1. Good will, unity, and cooperation between and among the various agencies and individuals serving the community;
2. A balance between proven expertise in the economic development field, on the one hand, and local involvement, development, and initiative, on the other;
3. The bringing together of the people of the community in common action, since the community's most valuable resource is its people;
4. Resolution of the problem of start-up capital, upon which abiding developments can be made;
5. The cultivation of a common vision, embodied in long-term and short-term plans, and approached systematically and cooperatively;
6. Effective and persevering management of the process of development, with tenacious attention to detail, regular communication between and among all involved, clear and specific delegation and allocation of responsibility, well-designed action calendars, and ongoing evaluation of both the process (methods, strategies, and activities) and the product (results and accomplishments) of development.
7. An ongoing and accurate assessment of the needs of the community, incorporating input and feedback from the community itself.

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 6

Pine Hill School Transportation
and
its impact on Ramah Navajo Community

PINE HILL SCHOOL TRANSPORTATION AND ITS IMPACT ON
RAMAH NAVAJO COMMUNITY

The successful operation of Pine Hill Schools would not have been possible without its school transportation services. The school transportation services made the difference in allowing Ramah Navajo Community parents to exercise basic rights that were denied them for over a hundred years. To have school transportation available allowed the excercise of parental rights in the preference of parents to have their children attend school from their homes. This choice impacted the asthetic quality of life for the parents and children. Parents were restored with the rights and responsibility to control the future destiny of their children.

The Pine Hill School has operated its school successfully for fifteen years. Throughout this period it has provided 98% of its student population with school transportation. The children of the community people live in a scattered living pattern perpetuated by both traditional economic conditions and historically by the checkerboarded land ownership base. Presently the future outlook of the community is to maintain their homes in this same pattern especially now that electrical power and indoor plumbing systems are being developed and constructed for the homes in this fashion. In addition, there is an increase in the number of homes based on natural population growth and home improvement programs. Also this year, some eighteen scattered mutual help homes will be built throughout the community. The parents of the community continue to strongly support and demand school transportation services for their children from their homes to the school on a daily basis.

In addition to daily transportationto school, the services also provides for students participation in after school activities. The Pine Hill School provides the only recreational program for this community's youth and due to the economic conditions of many parents, without school transportation services many children are not able to participate at all.

Although school transportation has provided an important and positive impact on the Ramah Navajo Community it still faces many complex problems that are not in direct control of the school and its transporation services. The most immediate and pressing need for school transporation services is two fold.

The need for an adequate level of funds to maintain transporation services with needed improvements for better communication equipment because of isolation and prolonged adverse weather conditions exists. The other need is of equal impact. There exists a need for a high level of consistent, reliable, and permanent maintenance of school bus roads with provisions for improvements.

BEST COPY AVAILABLE

The Bureau of Indian Affairs, Ramah Navajo Agency Roads Department is charged with total roads maintenance and improvement services for the entire Ramah Navajo Community reservation with the exception of State Highway 53 which runs east and west as the only state road. The BIA Roads Department presently maintain 26.8 miles of paved road, 6.4 miles of graveled roads, and 281.7 miles of dirt roads. Based on a 1974 BIA Roads map, this is only a fraction of the total existing roads. Presently, the Pine Hill School transportation services travels 681 miles a day with 57% of the travel being on paved improved roads and 43% of its travel on dirt unimproved roads. Basically, road maintenance is grossly inadequate to keep up with the road usage. Many problems exist with roads maintenance which contribute to school attendance, low academic performance and low student interest.

It is extremely neccessary that the transportation services be reliable and efficient especially when it has to cover great distances that take up to one and a half to two hours driving time one way to school. When children have to be picked up at 6:00 A.M. in the mornings in order to get to school on time by 8:00 A.M. the same children tire easily and cannot be expected to perform at optimum level. The lack of adequate roads and maintenance system sets off a chain reaction impacting negatively on the students at school.

Unimproved and dirt road conditions of the school bus routes causes an enormous vehicular wear and tear and an astronomical repair cost of the school buses every year. Unimproved and dirt road conditions poses hazardous conditions with the children's intellectectual growth in school activities.

In summary, school transportation services is a vital function of the Pine Hill School operation because it serves basic rights of parents and is the only means that allows children access to educational opportunities for the betterment of their lives. There exists discrepancy between the BIA Roads System and the Pine Hill School Bus Routes for 81.5 miles of roads not being accounted for and maintained. Lack of proper road maintenance with improvements for school bus routes and inadequate funds funds needed for maintenance of transportation services operation to cover wear and tear caused by travel on unimproved roads are immediate needs that impact on the education of children in the Ramah Navajo Community.

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC:

TESTIMONY, 01/10/86

Addendum 7

Adult, Community, and Non-formal
Education Needs Statement

COMMUNITY DEVELOPMENT

Indian communities, especially isolated areas, feel the affects of change more profoundly than other communities. The technological gap is widening and leaving the Indian community further behind. In our Indian families, we see the symptoms - intergenerational conflict, lack of communication between the elders and youth is evident. Young people have one foot in the 20th century and the other in the hogan. Internal conflict is inevitable.

Families have been and still are the key to Indian survival, yet, it's at the family level that most rapid disintegration is taking place. Extended family support systems are breaking down rapidly or already gone. The nuclear family in today's economy may not be the most viable structure. Quality time with youth is not possible, given the demands of making a living. Our youth are growing up without the support system or the experiential opportunities available to the youth of 50 years ago. Statistics say that 40% or more of the babies born in this country will be born into single parent families. In Indian communities the percentage may be higher. Implications are frightening.

Families have been the vehicle, in both Indian and non-Indian America, whereby attitudes, values and behaviors of each generation were passed on to the next, as the natural result of interaction between parents and children. Cultural transfer also occurred as youth grew up living and working along side parents. Family responsibilities played an important role in the growing up process. Responsibilities began at an early age and increased as youth grew older. Consequences were real and direct results of behavior. This process contributed significantly to the development of capable young people.

BEST COPY AVAILABLE

61-183 O - 86 - 6

As these circumstances have changed, so has the ability of the family to duplicate the processes needed to raise capable youth. As dependency increased for the family, the likelihood that independent people would be produced was affected. Dependency at the community level is now evident in Indian populations and the process of raising capable young people has been short circuited.

The results are evident; suicides, drug and alcohol abuse, teenage pregnancy, lack of success in school, all are serious problems in Indian communities.

Reaction of social programs on reservations is often aimed at rehabilitation, when in fact, habilitation has not occurred yet. The developmental process has been interrupted, largely due to an inability to adapt to rapid change.

"Indian Legislation" has had some positive impact, inspite of the general trend toward hand-out type programs. The opportunities that RNSB has been given have provided some important learning experiences. We have tried a number of approaches, mainly trying to replicate what the non-Indian community has to offer and, in some cases we've learned that it hasn't worked. In the area of Adult Education we've tried various approaches to adult basic literacy and learned several valuable lessons as a result of federal grants that enabled us to try approaches successful in the non-Indian world, unsuccessful with our population.

In vocational education we've learned that traditional approaches (in the non-Indian world) were not appropriate to our situation and only served to raise unrealistic expectations which were not met. As a result, we have had an opportunity, through federal grants, to develop approaches which recognize our unique situation and economic conditions and are more compatible

BEST COPY AVAILABLE

and supportive of traditional lifestyles and economic realities here.

What was critical was that we had the flexibility to try new approaches, to innovate and adapt to meet the conditions. Often in Indian education, K-12, we have been forced to play by the rules, established in Washington, many of which are not appropriate, do not take into consideration our unique environmental factors, and, most importantly, can change frequently (seemingly at the whim of uninformed bureaucrats).

Affects on Families -

Adult Education has strengthened the family by providing opportunities for parents, elders to learn some English, lessening the gap between themselves and the youth. The parents can then be more supportive when they can understand the importance of and the depth of the job the school has to do in educating Navajo youth.

Vocational Education has strengthened the families by providing opportunities that enhance the ability of the family to make a living at traditional livelihoods ie ranching, farming, agriculture, etc. We now provide training in Rural Technologies, skills needed to make a living in our environment and provide hands on opportunities to learn through our demonstration farm project.

Both Adult Ed. and Voc. Ed. have strengthened the family by providing opportunities to learn new skills in areas such as Home Economics, Livestock Management, Traditional crafts, inservice training for those already employed, as well as providing opportunities to complete high school through the GED program.

In addition, the community recreation program, sponsored by Adult Education has provided activities which are wholesome, creative outlets for both youth and adults in the community.

BEST COPY AVAILABLE

I. EDUCATIONAL NEED

The demographic, economic, and educational data contained in this section define the need for an Adult Education project on the Ramah Navajo Reservation. The data are taken from a variety of sources: a 1977 community survey; the 1982 Comprehensive Economic Development Plan of the Ramah Navajo Community; and data from the local Agency of the Bureau of Indian Affairs.

A. DEMOGRAPHIC CHARACTERISTICS

1. The Ramah Navajo Agency of the Bureau of Indian Affairs estimates a 1982 total resident Indian population of 1,793 on the Ramah Navajo Reservation.

2. A comparison of the age and sex distributions of the Navajo Nation and the U.S. populations in 1970 shows that the Navajo Nation population including Ramah is extremely young in comparison to national averages. There are several implications of a youthful population for the development of an economy:

   a. The dependency ratio is unusually high, i.e., the productive "working age" population must bear a greater burden of the dependent children and elderly,

   b. The relatively high proportion of young people places strains on already scarce resources; and

   c. The scarcity of resources and the limitations of economic opportunities often cause out-migration of college-age persons and young families.

3. The table below outlines the labor force characteristics of the Ramah Reservation for 1982.

BEST COPY AVAILABLE

General Assistance, etc. Over two-thirds of the Ramah Navajo households receive some type of public assistance and over seventy percent of the community, considering the size of its families, live drastically below USDA-established poverty levels.

C. EDUCATIONAL NEEDS DATA

1. More than half of the local adult population has less than a 6th grade education. However, number of years of formal education has been shown not to be an indicator of reading level or academic competence. Most of our basic literacy students have demonstrated little ability to speak, read, and or write English.

2. About 211 local Navajo adults have completed between 6 and 11 years of formal schooling. Of the 311 adult students with whom we have worked, the average reading level upon entry has been 3.5, and nearly all of the students are linguistically dominant in the Navajo language.

3. To summarize the above two items, about 73% of local Navajo adults have not completed high school, as reflected in the following statistics:

   - o 1,327 local adults total, over age 16
   - o 160 local high school graduates since 1974
   - o 100 GED graduates/diploma recipients since 1974
   - o 25 local adults with college degrees
   - o 75 local adults graduating from high school before 1974
   - o 967 local adults who have not completed high school (73%)

4. According to figures available from Pine Hill High School of the Ramah Navajo School Board, 86 young people dropped out of high school between 1975 and 1983. Considering an annual, average high school enrollment of 120 students, this interprets into an annual dropout rate of 9.5% to 10%.

5. Needs for Adult Education are clearly indicated in the foregoing data.

   a. While the percent of the adult population that has completed high school or GED has increased significantly, clearly there remains a significant portion of the Ramah Navajo adult population without

BEST COPY AVAILABLE

such training. Many GED and pre-GED students have in past years participated in Adult Education courses, but for many reasons were not able to complete. Others gained access to GED students by way of CETA employment, but CETA and related funds for the Ramah Navajo community have been drastically cut.

b. It is also clear that there is further need for ABE services in the community. The seeds of economic development are just beginning to germinate in this community, a direct result of our efforts to begin to produce people literate enough to become actively involved in the process. Continued community growth depends upon a ready labor force that is at least basically literate; much remains to be done in this area.

6. The following prioritized list interprets these matters into direct program needs. These needs come from an assessment conducted with adult students of the program:

a. There is a need for more buses and drivers capable of regular, dependable services, including on muddy roads.
b. English literacy training
c. Reading competency
d. Math competency
e. Money for educational trips
f. More money for the overall program of services
g. Night classes
h. More teachers
i. More workshops and seminar presentations
j. More and larger classrooms
k. Scheduling that will allow students to take classes all day every day.
l. More use of audio-visual materials
m. Navajo literacy training

D. CONCLUSION

In general, it remains a frustrating employment situation for most Ramah Navajo adults, due to the lack of local employment opportunities. In the nearby towns of Gallup and Grants, there are some opportunities, but most

BEST COPY AVAILABLE

TABLE II

PRACTICAL EDUCATIONAL NEEDS
OF A SAMPLE OF RAMAH NAVAJO ADULTS
N = 35

SKILL IDENTIFIED	# RESPONDENTS
CONSUMER SKILLS	
1. Knowing & deciding what community resource to turn to for help with a problem	3
2. Knowing what a budget is & how to use it; Figuring a family budget; how to match resources with needs, etc.	10
3. Finding the best buy at a store; how to make the best of food stamps, food budgeting, etc.	14
4. Knowing more about money - the various denominations, conversions and change, how to open up and use checking accounts, how to get loans, etc.	5
CITIZENSHIP SKILLS	
5. Reading a ballot	4
6. Knowing my legal rights, when to seek redress, etc.	2
7. Knowing how to drive safely and legally, pass driver's test, road signs, vehicle registration requirements, etc.	3
8. How to be a better meeting participant - Robert's Rules of Order, how to participate, what an agenda is, what the different government entities are and how they work, etc.	4
COMMUNICATIONS SKILLS	
9. Unable to communicate in English	3
10. Doesn't understand the technological aspects of social life.	?
HEALTH SKILLS	
11. Knowing more about emergency & first aid care	3
12. Knowing about home care for babies, handicapped, elderly, etc.	2
13. Knowing more about food - nutrition, how to prepare food for diabetics, babies & children, people with high blood pressure, use of commodity foods, etc.	9
EMPLOYABILITY SKILLS	
14. Knowing what the skill & performance requirements of a job are.	4
15. Reading a want ad, knowing how to use various resources for finding job opportunities, etc.	5
16. Filling out job applications	3
17. Knowing how to do job interviews, understanding hiring practices, etc.	4

BEST COPY AVAILABLE

BUSINESS SKILLS

18.	Knowing more about how to handle communications on the job - telephone, business letters, etc.	5
19.	Knowing how to market what I make - how to set prices, get more demand for the goods, conserve and recycle resources, etc.	7
20.	Learning to become a master at various Arts & crafts, all the way through to marketing and selling - including conversational and literacy skills to help with business, etc.	7
21.	Learning new crafts and how to read patterns, how to design my own things, etc.	4

PERSONAL SELF-MANAGEMENT SKILLS

22.	Filling out W-2, W-4, 1040EZ forms	6
23.	Reading and understanding a contract - employment, purchase, etc.	2
24	Computing job earnings	1
25.	Learning more about child development - traditional vs. modern practices, education, communicating with children, legal rights, setting goals for children, etc.	8
26.	Knowing more about home development - how to arrange, keep it in good shape, minor repairs, etc.	4
27.	Lacks the skills to obtain a standard home, e.g., the process of obtaining running water, power lines, and applying for Housing Assistance.	1
28.	Lacks the skill to understand Range Management for livestock and general management for deriving a profit from the livestock.	5

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 8

Statement by Katie Henio
Ramah Navajo Elder

Statement by Katie Henio
Ramah Navajo Elder

As an uneducated community member, I was only a sheep-herder when our community's only high school system was closed down. The Ramah Navajo School Board, Inc. was formed with Board members just about uneducated as I am. Yet they went after funds to start an educational system that would help the youth of our community. The school was open with teachers and parents helping out. I had started working in 1972. Later with future planning, school facilities were built in the midst of our community. We had graduates at the old school and we continue to graduate our children here at the new school. Community Education was stress with Bilingual Education being the most important. Our children must also retain our heritage, language and culture, at the same time preparing themselves to enter the new age of technological world.

We now see many of them going on to school, while others are working and hold jobs within the community. Yet we still have unmet needs. We are proud of our facilities, but we are overcrowded in many areas. We need a cafeteria and midschool to accommodate our growing enrollment. There are students who need boarding facilities. Presently, the board facility is over 20 miles away. The majority of our students live at home and ride the bus every day. The need to upgrade the roads so it's passable year round is great.

BEST COPY AVAILABLE

Page 2
Statement by Katie Henio

We as parents and grandparents have along with our children been attending school. Learning to write our names and the very basic to survive in an English speaking world. We also revived our traditional skills which was dying out, such as weaving, basketry and moccasin making. Our main problem prevents many of our adult students attending is transportation. We live in a vast area and depend upon others for transportation. There are no longer funds available for our Bus Transportation.

Our students are receiving a quality education, but we also need to enhence our childrens future skills with other activities such as art, competitive sports, music and other extra curriculum activities for which funds are not provided. I want my children and grandchildren to have a well-rounded quality education.

There are additional facilities needed.

BEST COPY AVAILABLE

RAMAH NAVAJO SCHOOL BOARD, INC.

TESTIMONY, 01/10/86

Addendum 9

Health Services

BEST COPY AVAILABLE

HEALTH SERVICES

Background and Development

Until 1978, the closest health facilities for the Ramah Navajo Community (operated by the Indian Health Service) were 45 miles away near Zuni, NM or 60 miles to Gallup, NM. As with the Ramah Navajo School, people of the Community felt that health services should be available close to home.

Acting under the Indian Self-Determination Act, Public Law 93-638, members of the incorporated Ramah Navajo School Board took their plans for a health facility to Congress and in 1977, Congress appropriated the money for construction and operation of a health center at Pine Hill.

Operations

In 1978, the physical plant was complete. Today, where no health care services had existed before, a primary health care center offers routine outpatient services which include well child care, dental, laboratory, pharmacy, x-ray, optometric, and audiological services. A field health unit provides a "bridge" between the clinic and the community where families do not consistently have available transportation or 4-wheel drive vehicles are required to reach them when the roads are otherwise impassable due to mud conditions. They assist community people in overcoming physical, economic, and cross-cultural barriers to the attainment of health care. Likewise, trained and certified Emergency Medical Technicians are on duty 24 hours, and community members are within a reasonable response time, to receive basic life support services and conveyance to emergency and inpatient facilities via ambulance.

For services not provided at Pine Hill, the Health Center has working agreements with hospitals and doctors in Zuni, Gallup, Grants, and Albuquerque, New Mexico.

The Pine Hill Health Center is supervised and supported by the Ramah Navajo School Board, Inc. The Board members provide community input, and make major decisions concerning operations and future planning of the Health Center.

Health Status of the Community

No good base line data exists for the health status of the Ramah Navajo Reservation, specifically. However, a general picture of health can be gleaned from analyzing data from the larger Navajo Reservation. In comparing the leading causes of death on the Navajo now with those of twenty years ago and less, one could conclude that the "epidemiological transition" has taken place; that is, that infectious and parasitic diseases have dropped from prominence to be replaced by the more chronic degenerative diseases such as heart disease, cancer, or diabetes. When compared with the leading causes of death for the U.S., there is essentially a similar pattern in conditions with differences in rankings.

BEST COPY AVAILABLE

Infant mortality, the most popular "sentinel" indicator of a population's health status, has been declining in the Navajo population over the past five years, narrowing the gap between the Navajo and the general population of the U.S., and almost on a par with it.

However, favorable comparisons in general end here. A significant difference between the Navajo population and the general U.S. population is in the age distribution. The Navajo population is much "younger" than the general population, with a median age of 19.8 years compared to that of 30 years. Only 5% of the Navajo population is over 65 years old while the figure is 11.3% in the general population (1979 IHS data). Data from the BIA (1982 Report on Labor Force), as well as recent Pine Hill Health Center counts of the population, confirm a similar picture for the Ramah Navajo Reservation. Thirty-three percent (33%) of Ramah Navajos are under the age of 15 years, and only 13% are over the age of 44 years.

Average life expectancy at birth for the U.S. population in 1980 was 73.7 years, 77.5 for females and 70 years for males, while average life expectancy for Navajos was 64.9, 71.8 for years for females and 58.8 years of males. This is an average difference of nearly nine years. It was estimated, using 1979 data from the National Center for Health Statistics, that the Navajo male life expectancy approximated that of a white male in 1928-31, and Navajo females that of white females in 1949-51.

What is alarming here is that, not only does the Navajo population have a higher dependency ratio than the U.S. population in general, but Navajos, both male and female, die in greater number at younger ages than their U.S. counterparts, up to the age category of 55 years and older. Moreover, Navajo males between the ages 15-34 have three times the death rate of U.S. males in this category, as well as Navajo females having twice the rate of U.S. females (1980 IHS data). This can only translate into a greater disruption of family earning power and stability where more dependents are concerned, as compared with the general population.

What is causing these deaths at a time when an individual should be developing skills, preparing for the prime bread-winning years? In 1980, for Navajos age 15-34 years, motor vehicle accidents was the leading cause of death (43%), mental disorders second (8%), and homicide and suicide third and fourth (7% and 6%). In 1980, cirrhosis and motor vehicle accidents had over four times the incidence among Navajos as the general population, and homicide nearly twice the incidence.

A contributing factor to these conditions (the nucleus of most) is the use of alcohol. This can be expected where unemployment is high, educational attainment marginal, opportunities are scarce, and individuals must struggle to make a difficult transition or adjustment to a dominant culture and a high tech society.

In summary, one can say that, in general, the health status of the Navajo, and the Ramah Navajo, is gradually improving, with gaps in certain areas between the general population narrowing, most significantly in infant mortality. This is due to policies backed by resources which decentralize facilities and programs, and bring the services closer to the people. Prime examples of this are public health nursing campaigns against tuberculosis of 30 years ago, outreach programs such as CHR and community health nursing, emphasizing maternal and health, and construction of primary health care centers closer to service

EST COPY AVAILABLE

populations. The legislative intent and spirit of the Indian Self-Determination Act and the Indian Health Care Improvement Act have been and should continue to be catalysts for increasing the role of local people in designing and delivering appropriate health services, and elevating the health status of Indians.

However, one must bear in mind that a high birth rate, lower life expectancy, and a pattern of higher death rates in middle age groups show the Navajo as still lagging behind the U.S. population. Health problems are changing for the Navajo, and are reflected in a lifestyle increasingly imposed by the "outside," and taking place in an atmosphere of relative economic under-development. New strategies are needed to address alcohol and substance abuse problems - programs that can address ever increasing mental health needs.

Community Outpatient Data

Ambulatory patient care reports for the Pine Hill Health Center tend to confirm the general picture of health described previously. According to IHS figures from Fiscal Year Ending September 1985, approximately 37% of visits to the Pine Hill Health Center were from those 19 years and younger. Those between the ages of 20 and 44 years accounted for about 33% of the visits. There were 14,874 total visits during this year.

The ten leading causes of outpatient visits for the fiscal year ending September, 1985 are as follows:

	Disease Category	Number of Visits
1.	Supplemental	3,871
2.	Diseases of Respiratory System	2,693
3.	Eye Diseases	1,574
4.	Ear Diseases	1,093
5.	Accidents	825
6.	Diseases of Digestive System	627
7.	Endocrine, Nutritional and Metabolic Disorders	586
8.	Infections and Parasitic	537
9.	Diseases of Skin	508
10.	Mental Disorders	333
		12,647

These ten categories account for 85% of visits to the Health Center. The Supplemental category is a catch-all for well child care visits, physical exams, lab tests, and other preventive services. Diseases of the Respiratory System are predominantly colds and viral infections. Refractive error accounts for 60% of the Eye Diseases category. Otitis media accounts for 86% of Ear Diseases. In the Accident category, 13% of the injuries were alcohol related. Diabetes mellitus accounted for about 90% of Endocrine, Nutritional, and Metabolic Disorders. Dental visits account for most of the Digestive Disease category. Strep throat and gastro-enteritis account for Infectious Disease, roughly half and half. About one-third of the visits in the Mental Disorders category are for schizophrenia and other psychoses.

BEST COPY AVAILABLE

A closer look at accidential injuries seen at the clinic from September, 1984, through September, 1985, reveals that 30% of motor vehicle injuries were alcohol related. Additionally, a full 62% of purposely inflicted injuries (assault and battery) were alcohol related. Of 18 cases of battery that occurred inside the home, 72% were alcohol related. In 1984, seven of the fourteen deaths (or 50%) in the Ramah Navajo Community were alcohol related. Anecdotally, in early Spring 1985, a 16 year old weas brought to the clinic dead on arrival, a victim of inhalent abuse (Liquid Paper). A nearly fatal incident of glue sniffing by school age children was interrupted by alert dormitory aides, and the participants given emergency treatment at the clinic.

This information points a picture of a predominantly "younger" population seeking care for conditions largely outside the purview of the more traditional public health interventions. Increasingly, disease patterns are shifting due to changing lifestyles, and the clinic is seeing more and more conditions related to alcohol and substance abuse - problems, the nature of which, fit better under the rubric of Mental Health.

BEST COPY AVAILABLE

PREPARED STATEMENT OF SALLY DAVIS, M.ED., INSTRUCTOR AND DIRECTOR, COMMUNITY/SCHOOL-HEALTH, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF NEW MEXICO, ALBUQUERQUE, NM, KEN HUNT, B.S. COORDINATOR, SCHOOL-BASED ADOLESCENT HEALTH PROGRAMS, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF NEW MEXICO, ALBUQUERQUE, NM

The health status of American Indian adolescents is far below that of non-Indian adolescents in the rest of the United States. Many of the health problems of adolescents are related to alcohol. Alcohol is, for example, a well known risk factor in accidents of all types. Accidental death rates, high for all adolescents, is 3.5 times as high for Indian and Alaska Natives aged 15 to 24.(13) In New Mexico the accident rate for Indians aged 15-24 is 285.3 compared to 111.2 for non-Hispanic whites and 105.7 for Hispanics. The rate for motorcycle accidents among New Mexico Indians aged 15-24 (76.6) is higher than for the United States (71.9) although it is comparable to other New Mexico adolescent groups (non-Hispanic whites 19.0, Hispanic-white 811.1).(12) Indian males in New Mexico are also more likely to drown than Indian females and non-Indians of either sex.

Alcohol abuse is a well-known health problem of all adolescents. May summarizes the extent of drinking reported by Indian youth as higher than that of non-Indians. Recent national surveys have shown that between 53% and 73% of all youth in grades 7-12 drink to some extent. Surveys of similar Indian youth show a slightly higher experience with alcohol: 56% to 89%, with three out of four studies above the 71% most often reported for all U.S. youth. Studies have shown that Indian youths drink for many of the same reasons as others in the United States. Factors such as peer pressure, recreation, experimentation, anxiety, and depression have been documented. In spite of similar reasons, the incidence is higher among the youth of most Indian tribes all around the country, it may be accurate to assume that alcohol use by Indian youth is more prevalent.

More specifically, alcohol abuse is a well-documented problem among the New Mexico Indian populations. The cultural phenomenon of drinking has been described in detail by Topper and others. For example the rate due to alcoholism among Navajos is 13 times the national figure. Alcohol use and abuse has been mentioned as a contributing factor related to accidents and suicide, the first and second leading causes of death in Indian adolescents in New Mexico. The fourth leading cause of death to Indians aged 15-24 is alcoholism with a rate of 20.4. It is not among the top five causes for Hispanics and whites.(12)

Alcohol is also related to another major cause of morbidity among teenagers. Again, the incidence is greater for Indians. In New Mexico suicide with a rate of 28.2 is the record leading cause of death for those ages 15-24 of all races compared to the U.S. rate of 12.4. For New Mexico Indians ages 15-24, the rate of 68.6.

The following documentations of suicides and suicide attempts for residents of the ACL area, although not broken out by ages, clearly points out the seriousness of the problem. As reported in the Albuquerque Area Tribal Specific Health Plan, July 1979, ACL had the second highest suicide rate in the Albuquerque area, 35.0 per 100,000. This was also higher than the average rate for Indians within the 24 reservation states and for the U.S. all races.

BEST COPY AVAILABLE

Emergency room records at ACL Hospital indicated a total of 9 suicide attempts during 1981, 8 of those occurring in December. In January, 1982, there were 2 attempts reported. Laguna Police records from a period of January 1981 through August 1982 indicate that there have been 16 completed suicides and 15 attempted suicides on the reservation during this period.

Currently, the suicide rate for the Pueblo of Laguna is 46 per 100,000. This is 3.6 times the national average rate of 12.8 per 100,000. In a study conducted by Dr. Phil May, Nancy VanWinkle and Valerie Montoya under an NIMH grant, suicide rates and patterns for several tribal groups in New Mexico were computed over a time period from 1957 to 1979. The rate for Laguna was 31, which was 22.3% of the total sample. This rate was the second highest among the 19 Pueblos in New Mexico. The study showed an increase in suicide rates over the years. After 1965, the rate for Laguna doubled.

The occurrence of pregnancy in the teenage population continues to warrant concern. Teen mothers and their babies are at a much higher risk for health problems as well as financial, educational and social problems. The babies of teen mothers are much more likely to die or have a low birth weight than are babies of older mothers. Indian women reportedly do not experience as high an incidence of low birth weight babies as other women in New Mexico do. Overall, 7.9 % of Indian babies in 1979 were of low birth weight cmpared to 8.1% of all state babies.

Teenagers living in New Mexico experience low health status similar to other Indian adolescents. There currently exists high rates of teenage pregnancy, drug and alcohol abuse, suicides and suicide attempts, accidents, self-destructive behavior, depression, domestic violence and family conflict. Until recently few programs existed which focused specifically on the adolescent population. Through community and university efforts several programs are now addressing these health issues through school-based teen centers. Schools are a logical location to reach the large numbers of school-aged children and youth. This is especially true in rural areas where free-standing programs, if they even exist, often miss students from outlying areas and those who do not have transportation other than the school bus. School-based programs make services both available and accessible.

School-based programs offering a range of comprehensive services maximize both effectiveness and efficiency. Schools will often provide space and utilities rent-free. By drawing from the community-at-large a program can share services with other agencies who may wish to reach adolescents, but have difficulty attracting them to programs that serve all ages.

The first of the school-based teen center models is outlined in the attached summary of the presentation made by Mr. Ken Hunt for the Select Committee on January 10, 1986, at the Laguna-Acoma Teen Center.

BEST COPY AVAILABLE

We strongly support this successful model that emphasizes comprehensive services provided by a multidisciplinary team located on campus. We encourage the development and use of incentives for cooperative efforts in funding and supporting cooperative efforts among schools, communities, universities, Indian Health Service, Tribal governments and state offices of Maternal and Child Health. Such partnerships make this type of effort feasible in times of reduced spending on prevention.

In addition, we believe that school staff should be educated and encouraged to support school-based teen programs by providing space and release time for students, but responsibility for direction of these programs should be done by health agencies.

BEST COPY AVAILABLE

Acoma-Canoncito-Laguna Teen Center
P.O. Box 349
New Laguna, New Mexico 87038
(505) 552-6922

Some Problems and Issues For Youth

No recreational activities in most areas
Limited recreation in some villages
None in Spanish communities

Very few jobs
only low income families qualify

If there were more activities available, there would be less involvement in alcohol, drugs

Summer Activities	Winter
Skating rink	Skiing
Game room	Tubing
Wilderness program	Theatres
Under 21 dance establishment	Fast food restaurant
Raft trips	Concerts
Concerts	

Why can't these be done?

- No money!
- Adults are not aware of youth needs
- Transportation is not available. If there was, more teens would participate in activities
- More attention is given to low-income needs
- Equal employment is needed
- Lack of motivation because of family ties
- Fear of succeeding in outside schools
- No teaching of living independently
- Inadequate college preparation
- Not enough support or sponsorship from adults
- Too many followers, not enough leaders
- Need to be taught:

Assertiveness
Motivation
Ability to say no
Public speaking

As identified by a group of Laguna-Acoma students, January 8, 1986.

Cosponsors: The Acoma-Canoncito-Laguna Teen Health Committee; United States Public Health Service, Indian Health Service; University of New Mexico, School of Medicine, Department of Family and Community Medicine.

BEST COPY AVAILABLE

ACOMA-CANONCITO-LAGUNA TEEN CENTER
P.O. Box 349
New Laguna, New Mexico 87038
(505) 552-6922

Chronology of Events

November 1982	Teen Pregnancy Task Force meets
May 1983	First proposal for funding intiated to OAPP proposal submitted to Indian Health Service, Maternal and Child Health
Summer 1983	University of New Mexico contacted Re: interest in contracting with IHS, Community Group Partnership
September 1983	Contract negotiated, project begins, community assessment begins (6 months) identify resources, services, persons Shift made from "Teen Pregnancy" to "Adolescent Health" Comprehensive services planned: clinical — education counseling — health promotion advocacy — prevention Program Manager, Physician hired
March 1984	Open House at Teen Center
Summer 1984	Teen Center open Sports physicals emphasized
September 1984	Staff Psychologist hired, counseling program stepped up End of 1st contract year, 2nd contract year begins
Oct-Dec 1984	Promotional Fun Runs at Laguna-Acoma Sky City Community School Canoncito Community School
March 1985	Students Against Driving Drunk (SADD) Conference attended with students from Laguna-Acoma, Grants
April 1985	SADD Chapter formed Laguna-Acoma Teen Health Awareness Day Improvisational Skit Performance

S. Davis/K. Hunt

January 10, 1986

BEST COPY AVAILABLE

Chronology of Events (continued)

May 1985	Sadd activities for prom, graduation: dial-a-ride bumper stickers wrecked car classroom presentations
	Senior Ditch Day several motor vehicle accidents senior killed
	Alcohol/Absentee Project begins
Summer 1985	Incoming senior killed by drunk driver Teen Suicide
	Alcohol and Substance Abuse Program (A.S.A.P.)/ Emergency Room experience "Trigger" film developed Peer Education Program begins
	Community Youth Forum on ETOH/Substance Abuse by peer educators
	National Indian Child Conference, Tempe, Arizona Workshop presentations: Teen Parenting Drinking and Driving Suicide Task Force begins
September 1985	2nd year contract ends, 3rd year contract year begins
	Nurse Practitioner added Alcohol Education Counselor Counseling staff expands Classroom sessions begin
	Improvisational skit group begins presenting issues in community meetings
November 1985	SADD presents skits, their purpose a National Indian Health Board Conference
	Community model of Suicide Task Force presented at National Indian Health Board Conference
December 1985	Secure building for Teen Health Program/Clinic for Canoncito Community
	Begin conducting clinic for sports physicals for Sky City Community School

S. Davis/K. Hunt January 10, 1986

BEST COPY AVAILABLE

Why School-Based?

*rural area
*school may be where kids spend a majority of their time
*transportation may be a major problem
*in/out migration is minimal
*no specific services strictly for teens
*teens normally do not seek out mental health/counseling/clinical services at community/local agencies
*school counselors/nurses may/may not be available or under-utilized by teens
*school may be underutilized by community

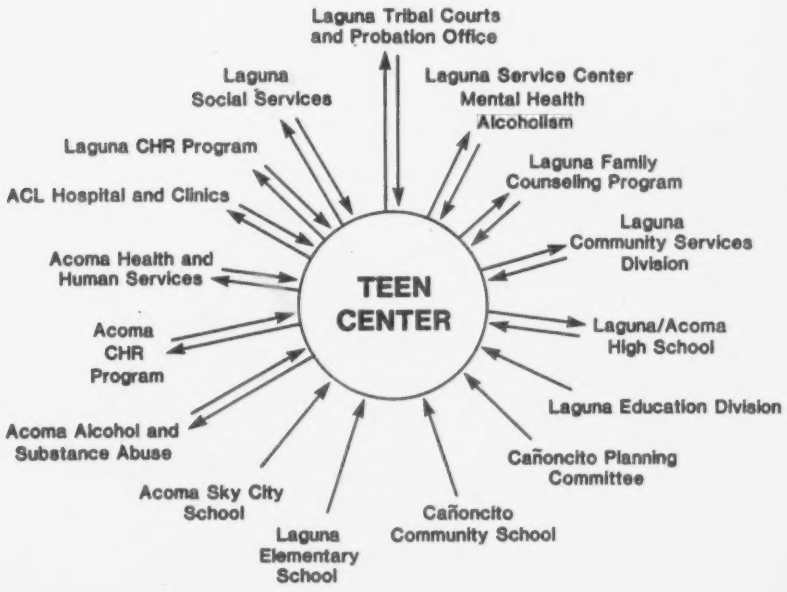
A Comprehensive Adolescent Health Program:

*is accessible to teens
*is strictly confidential
*has a staff that is responsive,caring
*has knowledge of resources in the community and has access to them
*can advocate on behalf of teens
*can provide education through a planned program in the classroom and as a part of curriculum
*provides other kinds of services: clinical, sports physicals, emergency care, first aid, screening, referral, follow-up
*can provide counseling through staff of community resources for: individual counseling
peer counseling
family counseling
parent support groups
teacher support groups
informal rap sessions
*Health Promotion, sponsorship, support through:
SADD
field trips
ASAP
fund raising
fun runs
workshops for parents
Teen Health Awareness Day
wilderness programs
skit groups
in-service training for teacher, student assemblies
*student advocacy
scholarships for leadership conferences, summer camps
health careers
support letters, typewriters, job bulletin board
Teen Center News
information for research papers

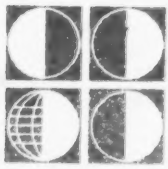
S. Davis/K. Hunt January 10, 1986

BEST COPY AVAILABLE

A C L Teen Center
Referral System and Network of Services



Epidemiology of Fetal Alcohol Syndrome Among American Indians of the Southwest



*Philip A. May, †Karen J. Hymbaugh, ‡Jon M. Aase, and ‡Jonathan M. Samet

**Department of Sociology, University of New Mexico, Albuquerque, New Mexico; †Department of Public Administration, University of New Mexico, Albquerque, New Mexico; and ‡School of Medicine, University of New Mexico, Albuquerque, New Mexico*

ABSTRACT: The epidemiological features of Fetal Alcohol Syndrome (FAS) were examined among American Indians in the southwestern United States. All FAS suspects were screened in specific populations of Navajo, Pueblo, and Plains culture tribes. A total of 115 alcohol-affected children were identified. The incidence of FAS was found to be highly variable from one cultural group to the next, ranging from 1.3 per 1,000 births (1/749) for the Navajo to 10.3 (1/97) for the Plains. The pattern of age-specific prevalence indicates an increase over the past fifteen years. The overall rate of mothers who have produced fetal alcohol children was 6.1 per 1,000 women of childbearing age with a range of 4 to 33 per 1,000. These maternal prevalence rates were important for the accurate prediction of public health risk because 25 per cent of all mothers who had produced one affected child had also produced others. The average per mother was 1.3 alcohol-affected children. Other findings indicate that the mothers of these children led highly disruptive and chaotic lives and were frequently isolated from mainstream social activities. In general, the gross social and cultural patterns of the tribes studied can readily explain the variation in incidence of FAS.

In 1979, the International Year of the Child, the Indian Children's Program of the Indian Health Service (IHS) convened an expert committee to select a public health project of major importance to Indian children. This group decided to establish a Fetal Alcohol Syndrome (FAS) Project for two reasons. First, those with extensive clinical experience among Indians perceived FAS as a new and increasing problem among Southwestern tribes. Second, the early FAS literature had already identified some American Indian children with FAS (Smith et al., 1976).

The resulting FAS Demonstration Project had three goals. First, the program was to provide education and training in the recognition and prevention of FAS for health care providers, human services workers, and local community groups. Second, the program was to offer evaluation by a pediatric dysmorphologist to all FAS suspects and initiate a treatment plan for children with FAS and other developmental problems. Third, research was to be undertaken to assess the incidence of FAS among American Indians. The complete project is described in detail elsewhere (May and Hymbaugh, 1983). This paper will focus on the third goal.

Fetal Alcohol Syndrome refers to a pattern of malformations found in children whose mothers drank alcohol excessively during pregnancy. The most common features are: varying degrees of mental retardation and CNS dysfunction, reduced birth length and weight, microcephaly, hypoplastic midface, growth deficiency throughout life, certain joint abnormalities, frequent cardiac defects, and hyperactivity (Jones et al., 1973; Jones and Smith, 1976; Rosett

186
BEST COPY AVAILABLE

et al., 1976; Streissguth et al., 1980) Recently, it has been recognized that moderate and/or binge drinking may cause less severe forms of developmental damage. Thus, the teratogenic effect of alcohol can be conceptualized as a spectrum. Heavy drinking may result in the complete FAS, whereas lower levels of consumption may cause lesser mental and growth defects (Rosett, 1974, 1976; Streissguth et al., 1978; Eckardt et al., 1981).

In the U.S. and Europe, FAS is a frequently documented birth defect. Although several hundred clinical and experimental studies of FAS among humans and animals have been published, the epidemiology of FAS has not been well characterized. Data are currently available only for Seattle, Washington (Streissguth et al., 1980), Goteberg, Sweden (Olegard et al., 1979), and Roubaix, France (Dehaene et al., 1977, 1981). Estimates of the incidence of FAS vary from 1 in every 600 babies in Sweden and 1 in 700 in France, to 1 in 750 in Seattle. Fetal Alcohol Effect (FAE), a milder form of in-utero damage, has been reported in France and Sweden with an incidence approximately equal to that of FAS. Each of the above rates is based on cumulative clinical experience and not on a survey of a specific population. FAS documentation is currently not available in large national data bases (Eckhardt et al., 1981) and probably will not be in the near future. The present study is therefore unique in determining the magnitude of FAS in a defined population.

MATERIALS AND METHODS

Indian Groups Studied

The Indians of this study are from three very different cultural and social traditions. The Pueblo Indians have inhabited the southwestern United States for 10,000 years or more. Their traditions emphasize sedentary, pastoral, and agricultural pursuits, and their social integration is matrilineal, complex, and strongly "emphasizes conformity with the larger (community based) group" (Dozier, 1970).

The Apache and the Ute tribes are the Plains culture groups in this study. These tribes migrated to the Southwest approximately 1,000 years ago. The nomadic, hunting, gathering, and raiding tradition of their culture is in many ways a polar opposite to the Pueblo. In Plains culture tribes, individuality is encouraged and some flamboyant behaviors such as risk-taking, drinking, and defiance are tolerated and may be encouraged. The largest permanent level of Plains social organization was traditionally a band of several allied extended families (Schroeder, 1974).

The Navajo cultural traditions are a mixture of the Pueblo and Plains traditions. The Navajo came from the same Plains traditions as the Apache, but in the past three hundred years they have adopted many traits of the Pueblo. Therefore, the Navajo patterns of social integration and behavior regulation are intermediate between the Plains and Pueblo. The Navajo emphasize conformity to group norms, but allow more individualized behavior than the Pueblo (Kluckholn and Leighton, 1962).

The contemporary socioeconomic status of southwestern Indians shows some variation within each culture, for the individual tribal cultures are in various stages of modernization and transition (Kunitz and Levy, 1981). Many young Indians are upwardly mobile due to recent educational and economic opportunities, but the majority of the indi-

viduals and tribes are characterized by low education and limited economic development. Nevertheless, the overall differences in social integration still exist and influence behavior as evidenced by alcohol-related mortality statistics. The Plains tribes have consistently higher death rates from flamboyant behaviors such as accidents, suicide, and homicide (U.S. Public Health Service, 1978, 1979; VanWinkle, 1981; Reidy, 1982)

In sum, the three cultural traditions of these tribes generally produce different types of behavior (May, 1982). Particularly, their differing alcohol-related behaviors must be considered in evaluating the epidemiology of FAS.

Methodology

The study was undertaken in 1980–82 among American Indians of New Mexico, Southern Colorado, Southern Utah, and Northern Arizona. Indian groups served by the project resided on 26 reservations with a total population in 1980 of approximately 240,000 (U.S. Dept. of Health, Education, and Welfare, 1979). Because the land area served was vast, transportation and logistics were major obstacles and determinants of the study design.

An elaborate referral system served as the basis for this study. All research activities were coordinated on each of the outlying reservations from the central office in Albuquerque. The major focal point on each reservation was one of the eleven hospitals or ten full-time clinics operated by the IHS. At each of these installations, explicit and detailed training on the recognition and diagnosis of FAS was provided to all IHS clinical staff by the project staff and two consultant dysmorphologists. These diagnostic training sessions were two-hour slide and data presentations detailing the clinical characteristics of 15 FAS and FAE children from birth to 17 years of age. Further literature on FAS was subsequently provided to trainees. In each session the FAS Demonstration Project was explained, with specific instructions concerning referral of suspected FAS children. To complement the training and facilitate referral, all physicians and nurses trained were provided with a three-page referral form for FAS suspects. Items included on this form were key aspects of the parents' medical and alcohol use histories; birth length, weight, and head circumference of the suspect, and a simple checklist of 29 characteristics generally found in FAS. In addition, the referring clinicians were asked to attach growth charts, developmental test results, and other relevant information.

At each clinic or hospital one or two "designated persons" were the major liaisons with the project. The project staff at the central office worked closely with local staff to review and verify the records of the referred child and of his/her parents. Referrals were encouraged for any child considered suspicious because of clinical features of FAS and a maternal history of drinking. The primary emphasis in ascertainment was on children under 15 years of age. FAS suspects were then scheduled for clinics at the health installation from which they were referred. The project staff and one or more of the project dysmorphologists traveled to the outlying clinic where data collection and diagnostic evaluations were completed.

To standardize the final diagnosis, a weighted diagnostic form was developed for the project by a committee of

seven experienced dysmorphologists. The form consisted of 36 separate diagnostic items divided into four sections: drinking history, radiologic findings, growth and development, and clinical observations. The section on clinical observations contained eleven subsections: general observations, lateral facial profile, ear, eye, nose, neck, chest, arms, and hands, heart, back, and skin.

Screened children were categorized for project purposes as FAS, FAE, suspicious, or without signs of fetal alcohol damage. Two diagnostic categories, FAS and FAE, were used for definite alcohol damage. For the diagnosis of FAS, all of the following were required: (1) prenatal and postnatal growth deficiency; (2) mental deficit and development delay; (3) facial dysmorphia; (4) physical abnormalities; and (5) documentation of alcohol abuse during pregnancy. FAE designated a milder form of prenatal alcohol damage with the child having all of the features of FAS, but to a lesser degree. A diagnosis of "suspicious" indicated that the child met many of the criteria of FAE, except for adequate evidence of abusive maternal drinking. Without exception, all diagnoses were made by two dysmorphologists, who both have considerable experience with FAS and American Indians. The major orientation for the diagnosis was toward future therapy and habilitation of the child (May and Hymbaugh, 1983).

Alcohol histories of the mothers and some fathers were obtained from multiple sources. In most cases, adequate documentation was available in medical charts through notes and visits for alcohol-related illness and trauma. Records of local and tribal police, and social welfare agencies were also consulted. Additional informants, such as clinic and field health personnel, relatives, friends, and social service workers were used to further substantiate the history. A strict quantitative definition of alcohol abuse was not possible. Verification was assumed when all sources were in complete agreement that alcohol abuse was common during pregnancy. Since most of these reservations were quite small and of restrictive residence, these informants were quite aware of the drinking patterns of the mothers.

Population data used in the analysis were derived from Indian Health Service estimates. These estimates were based on 1970 U.S. census data, actual Indian births and deaths, and net county migration (U.S. Dept. of Health, Education, and Welfare, 1979) They were the latest available figures which were age- and community-specific.

Two different rates were calculated to describe the occurrence of FAS and FAE. Prevalence rates for children ages 0–14 were calculated with 1979 population estimates as the denominators. To approximate the incidence of FAS and FAE at birth, the actual natality was reconstructed by combining the 1979 population estimates and mortality experience from life tables.[1] The Navajo data were corrected with a tribe-specific life table (Carr and Lee, 1978), whereas the Pueblo and Plains figures were adjusted with a life table for all U.S. Indians (Indian Health Service, 1975). The incidence was then calculated as the ratio of

[1]It would have been preferable to use actual births for the denominator, but this was not possible because tribal affiliation is not recorded on birth certificates and because of the IHS system of aggregating birth date.

BEST COPY AVAILABLE

the total number of cases to the total number of births.

The prevalence of mothers who had produced an FAS or FAE child was also calculated. The denominators for these rates were the 1974 estimates of women aged 15–44 years. Since the children ages 0–14 in 1980 were born between 1967 and 1981, 1974 is the midpoint year.

Overall rates in each table were calculated for the entire population covered by the FAS project in the Southwest. These rates were adjusted by the direct method with weights proportional to the representation of each culture in the entire study area.

In the results section data are presented for individual reservations and service units. The specific reservations and tribes are not named to avoid stigmatization. Therefore, the results are reported in a way that cites important identifying cultural information, but pseudonyms are used for the particular subtribes, reservations, or areas studied.

RESULTS

The FAS project held 23 clinics in sixteen different locations. Of the 243 children evaluated, 31.3 per cent had FAS, 16.0 per cent had FAE, and 5.3 per cent were considered suspicious (Table 1). Among the 47.4 per cent diagnosed as not having FAS, most were diagnosed as normal. Other specific anomalies were found in 12 per cent of the children examined, including hypoparathyroidism, blepharophimosis and Down, Melnick-Needles, Fetal Hydantoin, Noonan, and Cornelia deLange syndromes.

The average birth measurements of the diagnosed children were consonant with FAS in other populations when compared with standard growth charts. Indian FAS children were small at birth in length (mean = 17.3 inches, predicted = 20), weight (mean = 4.6 lbs., predicted = 7.5), and head circumference (mean = 12.2 inches, predicted = 13.6) (National Center for Health Statistics, 1976). Other studies have shown that normal Southwest Indian babies are heavier and longer at birth (Adams and Niswander, 1968), than those of other U.S. populations. Growth patterns for the first two or three years of a child's life were particularly important in diagnosing this condition. Some of the children diagnosed as having fetal alcohol effect were "low normal" (e.g., 10th percentile) at birth on standard growth charts, but their growth curves showed inadequate

TABLE 1

DISTRIBUTION OF DIAGNOSES OF PATIENTS EVALUATED IN FAS PROJECT CLINICS

Diagnoses	Total	Per Cent	Male	Female	Sex Ratio*
Fetal Alcohol Syndrome (FAS)	76	31.3%	41	35	117
Fetal Alcohol Effect (FAE)	39	16.0	26	13	200
Suspicious	13	5.3	4	9	44
Other/Not FAS	115	47.4	64	51	125
Total	243	100%	135	108	125

*Sex ratio (males per 100 females)

BEST COPY AVAILABLE

growth, resulting in a marked "flattening" of the curve and a decline in percentile rank in their first few years.

The detailed epidemiological analyses which follow were limited to the seven service units and reservations where ascertainment was judged to be complete by project staff and local health personnel (Table 2). The fertility rates of these tribes during the past fifteen years were comparable and the age structures of these different reservation populations were similar. In these areas there were 55 FAS children and 30 FAE children (aged 0–14) among a total 1979 population of 51,137 of which 22,963 were aged 0–14. Four alcohol-affected children 15 years or older were also found. The Plains groups have the highest rates, with the Navajos and Pueblos lower. Although the rates vary slightly within each group, those for the Navajo and Pueblo are quite comparable to data from Seattle, Sweden, and France (Streissguth et al., 1980; Olegard et al., 1979; Dehaene et al., 1981). The incidence among the Plains tribes exceeds the upper range of any previously reported rates, but the overall culture-adjusted rates are quite similar to previous studies. Age-specific prevalence rates were lower in the older ages (Table 3), with the exception of Plains reservation N.

One unanticipated finding in this research was the frequent occurrence of two or more alcohol-damaged children born to one mother (Table 4). On the completely screened reservations, 85 FAS or FAE children were born to 65 mothers, an average of 1.3 affected children per mother. Fifteen mothers produced more than one damaged child, among them one set of twins (dizygotic). Variation in the pattern of recurrent affected births were found between tribal

TABLE 2

BIRTH INCIDENCE AND PREVALENCE (AGES 0–14) OF FETAL ALCOHOL CHILDREN BY CULTURAL GROUP AND SERVICE UNIT* OR RESERVATION†

CULTURAL GROUP AND SERVICE UNIT OR RESERVATION	FAS			FAS & FAE		
	Birth Incidence	FAS (All Births)	Preval. in Ages 0–14	Birth Incidence	FAS & FAE (All Births)	Preval. in Ages 0–14
Navajo Culture	1.4	(1/690)	1.6	2.2	(1/448)	2.5
Service Unit–F	1.5	(1/655)	1.7	2.2	(1/447)	2.5
Service Unit–W	1.3	(1/749)	1.5	2.2	(1/449)	2.5
Pueblo Culture	2.0	(1/495)	2.2	2.4	(1/408)	2.7
Reservation–W	1.5	(1/660)	1.7	2.1	(1/471)	2.3
Reservation–N	5.9	(1/170)	6.4	7.8	(1/128)	8.6
Service Unit–C	1.9	(1/522)	2.1	1.9	(1/522)	2.1
Southwest Plains Culture	9.8	(1/102)	10.7	17.9	(1/56)	19.5
Reservation–S	10.3	(1/97)	11.3	17.6	(1/57)	19.2
Reservation–N	9.2	(1/109)	10.0	18.3	(1/55)	20.0
Total Culture Adjusted Rate†	1.8	(1/633)	2.0	2.8	(1/427)	3.1

*A service unit is a geographical area served by a single I. H. S. administrative unit, usually characterized by one major hospital or clinic.

†Rates per 1,000.

‡Adjusted by the direct method to the proportion of each culture in the entire Southwest study area.

BEST COPY AVAILABLE

TABLE 3

AGE-SPECIFIC PREVALENCE RATES FOR FAS AND FAS/FAE COMBINED, BY CULTURAL GROUP AND SPECIFIC LOCATION*

CULTURAL GROUP	FAS		FAS & FAE	
	Ages 0-4	5-14	Ages 0-4	5-14
Navajo Culture	3.7	0.5	5.2	1.0
Service Unit–F	4.4	0.3	6.2	0.7
Service Unit–W ...	2.7	0.7	3.7	1.5
Pueblo Culture	4.7	1.1	5.7	1.3
Reservation–W ...	4.1	0.5	5.2	1.0
Reservation–N ...	16.3	2.9	24.4	2.9
Service Unit–C ...	3.7	1.5	3.7	1.5
Plains Culture	11.7	10.2	17.5	20.5
Reservation–S	19.9	6.8	26.6	15.3
Reservation–N ...	0.0	14.4	4.7	26.7
Total Culture Adjusted Rate	4.2	1.0	5.7	1.8

*Rates per 1,000.

cultures, but the differences are not readily interpreted because of small numbers.

The prevalence of mothers with damaged offspring was lowest among the Pueblo and Navajo, and much higher among the Plains tribes (Table 4). These rates are useful in measuring the extent and origin of risk in each population.

Social maladjustment, high-risk lifestyles, and high mean maternal age at birth of the damaged children were characteristic of the mothers in this study (Table 5). Of the fetal alcohol children, 73 per cent were adopted or in foster placement. In most cases, the child had been left with relatives or friends, abandoned, or other neglect was documented. In 23 per cent of the cases, the mother was dead, almost always from accidents, cirrhosis of the liver, or other alcohol-related trauma and illness. There was variation by culture, with the lowest mortality in the Navajo and the highest in the Plains. The screening process used could have increased the proportions of deceased mothers and children in foster placement, if foster parents were more likely to have their

TABLE 4

VARIABLES CONCERNING MOTHERS BEARING MULTIPLE AFFECTED CHILDREN AND MATERNAL PREVALENCE BY CULTURAL TYPE AND LOCATION

CULTURAL GROUP AND SERVICE UNIT OR RESERVATION	MOTHERS PRACTICING MULTIPLES*	FETAL ALCOHOL CHILDREN PER MOTHER†	MOTHERS BEARING FAS & FAE CHILDREN PER 1,000 WOMEN 15-44 YEARS OF AGE
Navajo Culture	21.4%	1.3	5.3
Service Unit–F	26.7%	1.5	4.9
Service Unit–W	15.4%	1.2	5.9
Pueblo Culture	25.0%	1.4	4.6
Service Unit–W	20.0%	1.4	3.9
Reservation–N	50.0%	2.0	8.0
Service Unit–C	20.0%	1.2	4.5
Plains Culture	28.0%	1.2	30.5
Reservation–S	30.8%	1.3	33.3
Reservation–N	25.0%	1.2	27.9
Total	24.6%	1.3	7.5
Total Culture Adjusted Rate	22.3%	1.3	6.1

*Per cent of mothers who have produced two or more FAS or FAE children.
†The total number of FAS and FAE children divided by the number of mothers producing them.

BEST COPY AVAILABLE

TABLE 5

SELECTED SOCIAL VARIABLES OF MOTHERS, FETAL ALCOHOL CHILDREN, AND OTHER CHILDREN

VARIABLES	FAS & FAE	Not FAS & Other Diagnosis	Signif. Level*
Children in foster placement	73.3%	42.5%	$p = 0.02$
Deceased mothers	23.1%	15.7%	$p = 0.10$
Navajo	10.7%	5.8%	...
Pueblo	25.0%	5.0%	...
Plains	36.0%	29.5%	...
Average age of mother at birth of FAS child†	29.7	26.9	$p = 0.02$
Navajo	28.1	27.8	...
Pueblo	32.6	26.6	...
Plains	30.7	26.3	...

*Significance level determined by Z test. Ellipsis dots indicate significance level not reported because of small numbers.
†Age at delivery for mother was not available for 16 of the 65 mothers of fetal alcohol children.

children evaluated. Mothers bearing FAS and FAE children had a mean age at delivery of 29.7, higher than that of the mothers of the non-FAS children seen and higher than the mean age at delivery for all Navajo mothers (24.8) (Broudy and May, 1983). Of all of the mothers who produced FAS and FAE children, only 18 per cent were under the age of 25.

DISCUSSION

A referral network and clinical screening system were used to identify prevalent cases of FAS and FAE in southwestern American Indian groups. This approach was determined largely by feasibility issues and may have limitations for the epidemiological analyses of this paper. First, the adequacy of case-finding cannot be independently verified. Accordingly, we limited the calculation of prevalence and incidence to the populations where screening was known to be satisfactory. The resulting rates (Table 2) were comparable to or higher than those from other populations (Streissguth et al., 1980; Olegard et al., 1979; Dehaene et al., 1981); thus, bias from incomplete ascertainment appears unlikely. Second, alcohol histories were not obtained directly from the mothers. However, the combination of medical records and community informants was generally sufficiently sensitive to identify abusive drinking during pregnancy. Third, calculation of incidence rates for FAS and FAE required a pragmatic reconstruction of birth numbers. This approach also assumes no deaths among children with FAS and FAE and, as a result, probably underestimates the actual incidence. Fourth, a similarly pragmatic technique was used to calculate the prevalence of mothers who had given birth to an FAS or FAE child (Table 4). Mid-point population figures were used to estimate the numbers of women at risk for giving birth to an alcohol damaged child. Although this approach is relatively crude, the prevalence estimates should provide a

BEST COPY AVAILABLE

satisfactory measure of inter-tribal variation.

With these limitations in mind, the incidence of FAS among Southwestern Indians can be compared to previously reported rates. The Navajo rate (1 per 690 births) and overall rate for Southwest Indians (1 per 633) are lower than that reported for Seattle (1 per 750) and fall between the rates for Roubaix, France (1 per 700) and Goteberg, Sweden (1 per 600). The Pueblo rate of 1 per 495 is higher than those for all the comparison populations. The Plains incidence of 1 per 102 births is much higher than any previous figures reported. The overall incidence of FAS and FAE found among Southwest Indians, 1 per 427, is quite comparable to the estimates from France and Sweden, although the criteria used in this study may be more strict than those used in Europe.[2]

The age-specific rates (Table 3) raise three interesting thoughts. First, the literal interpretation is that the occurrence of FAS and FAE is increasing among the groups, especially among the Navajo and Pueblo. Second, the screening process might have been effective in identifying younger children. Third, fetal alcohol children may have unusually high mortality experience in their early years.

Attention can now be turned to possible explanations for the variability in occurrence of FAS in the three American Indian populations studied. Among the possible explanations for this disparity are innate biological differences among the groups, either in the liability for prenatal alcohol damage or in the metabolism of ethanol itself, differences in the teratogenic agent, or sociocultural differences among the tribes studied.

Biological Considerations

While a number of studies in the past have attempted to show differences between Indians and Caucasians in the rate or extent of alcohol breakdown, no convincing differences have been substantiated. The common stereotype of the "drunken Indian" has not been borne out either in terms of aberrant metabolism of alcohol (Reed et al., 1976; Schaeffer, 1981), liver biopsies (Bennion and Li, 1976), or in the proportion of the Indian population abusive of alcohol (May, 1982). Furthermore, there is no evidence for a genetic component in production of the Fetal Alcohol Syndrome, for the type and severity of its manifestations are identical in Indian and non-Indian children (Aase, 1981). While it would be premature to rule out innate metabolic differences of a subtle kind, or the presence of some environmental or genetic cofactors which influence the occurrence of FAS, there is presently no valid information which points in this direction (Schaefer, 1981).

Substrate Differences

Conceivably, there might be some ingredient in the different alcoholic beverages consumed by different groups which might account for different risks for FAS in offspring of alcoholic women. In previous surveys, the type of beverage consumed had no discernible influence either on the incidence or the severity of FAS in children of drinking mothers. Total alcohol intake seems to correlate best with these outcomes (Iber, 1980), but even this seems to be

[2]Personal communication with Ann P. Streissguth, Ph.D., University of Washington, and Kenneth Warren, Ph.D., NIAAA.

61-183 O - 86 - 7

BEST COPY AVAILABLE

variable, since more than half of the offspring of severely alcoholic women seem to be protected from the effects of maternal alcohol abuse (Jones and Smith, 1976; Rosett et al., 1976; Streissguth et al., 1980). In our study, the usual variety of alcoholic beverages was consumed both by mothers of affected and unaffected children. Also, alcohol is definitely the drug of choice among the adults of the study population (May, 1982; Levy and Kunitz, 1974).

Sociocultural Factors

For the purposes of this discussion, sociocultural factors can be viewed as creating expectations which either foster or inhibit individual drinking behavior and also influence the style of consumption. In considering maternal drinking patterns, four considerations need attention: rate, severity, and duration of alcohol abuse in women of childbearing age, and the timing of alcohol intake in relation to the gestation in question.

National surveys indicate that 60 per cent of all U.S. women consume some alcohol (National Institute on Alcohol Abuse and Alcoholism, 1981), while surveys among the Navajo and Plains tribes show that only 13 to 55 per cent of women drink (Levy and Kunitz, 1974; Longclaws et al., 1980; Whittaker, 1962, 1982). Certain subsegments within each tribe, however, have significant alcohol abuse problems as evidenced by high rates of death from accidents, liver cirrhosis, and other alcohol related causes (U.S. Public Health Service, 1978, 1979) among Indian men and women (Streissguth, 1980).

In these groups, certain distinct social factors may have a profound influence on the severity of alcohol abuse in women and the resulting incidence of FAS and FAE. While the per cent of population drinking within each tribe influences the findings, drinking style is more relevant to severity of abuse. For example, the highest percentage of drinking women is found among the Plains tribes (50-55%; Whitaker, 1962, 1982), with considerably lower percentages among the Pueblo and Navajo (13-23%; Levy and Kunitz, 1974). As expected, the Plains tribes had the highest incidence of fetal alcohol damage. However, the Plains rate of FAS and FAE (in Table 2) is five (4.9) to seven (7.0) times higher than the other tribes, much higher than would be dictated solely by the proportion of drinkers. This is due to the normative pattern of social regulation. The Plains tribes allow for considerably more individuation of behavior, especially alcohol-abusive behavior (Jessor et al., 1968; Curley, 1967). More Plains women are permitted to follow abusive behaviors, while the low incidence rates of the Pueblo and Navajo exemplify tighter control exercised on individuation and alcohol abuse. Bearing an alcohol-damaged baby is not condoned in the mainstream of any of these tribal groups, but it is more common with the loose social integration of the Plains groups.

Social variables can also influence drinking severity and FAS in some special circumstances. An example from our study clearly demonstrated that alcohol abuse rates can be atypically high at certain times which clearly puts more pregnancies at risk. One small Plains reservation (reservation N) with a high incidence of fetal alcohol problems had received royalties for a number of years from the sale of resources extracted

from their lands. Payments of approximately $100 per month were distributed to adult tribal members on a per capita basis. For various reasons, the tribe suspended the payments in the late 1970's, and the prevalence of fetal alcohol syndrome appears to have decreased dramatically (Table 3). Of the fourteen Fetal Alcohol children found on this reservation under the age of 15, only one FAE child had been born after the cessation of per capita payments.

Ostracism from a tribal culture may also affect the severity of alcohol abuse. As in most areas of the United States, female Indian adolescents usually experiment with alcohol, but as they grow into their twenties, societal rules become more strictly enforced. Among the Plains tribes more variation in drinking behavior is afforded women, but among the Navajo and Pueblo a woman who continues drinking is much less likely to be tolerated or accepted, especially among the Pueblo. More clearly than in many societies, traditional Pueblo or Navajo people enforce a definite choice on most of their women—to abstain or to be partially or totally ostracized. Those who continue regular or heavy drinking are removed from participation in most family and tribal activities. Once this occurs, stigmatization fixes their alcoholic life style and promotes increased severity of abuse.

Informants consistently reported the ostracism pattern for mothers who produced two or more children with fetal alcohol damage. They were often characterized as unreachable and far removed from mainstream tribal society. We postulate that ostracism maintains the severity and duration of abusive drinking and thus may explain the birth of multiple affected children to a single mother and also the higher rate of FAS among the Pueblo than among the Navajo. Support for this hypothesis is the ratio of FAS to FAE. The ratio is very different between tribes (Table 4). In the Plains groups there are as many FAE children produced as FAS (approximately 1 to 1), while among the Navajo and Pueblo the ratio is approximately 2 to 1 and 4 to 1 respectively. This variation is consistent with the anticipated effects of ostracism and drinking behavior, since the Pueblo exercise the strongest ostracism and the Plains the weakest.

Ostracism may also prolong the duration of alcohol abuse. Among American Indian groups, the period of childbearing is longer than that of the general population (Broudy and May, 1983). The combination of sustained alcohol abuse and this prolongation of childbearing years increases the risk for FAS. In this study a pattern of successively more severely affected offspring was repeatedly observed. Among the women who produced more than one fetal alcohol child, the later children always were diagnosed as having equal (47 per cent) or more severe damage (53 per cent). Therefore, as long as a mother continued to drink, the degree of severity of symptoms increased with each succeeding child. However, several cases indicated that if a mother quit drinking in subsequent pregnancies, normal children were born.

CONCLUSIONS

The ascertainment method used in this study employed several successive levels of screening for children suspected of having Fetal Alcohol Syndrome. This technique, with a weighted

checklist of FAS characteristics used in the final screening, was quite cost-effective and yielded reliable prevalence figures for the three American Indian groups surveyed. While not a guarantee of 100 per cent ascertainment, this approach may prove useful in further epidemiologic studies of FAS and other teratogenic conditions in limited populations to permit assessment of risk and planning for intervention.

Analysis of the data gathered in this study showed consistent differences in incidence and patterns of recurrence of FAS among the three subject groups. These differences were of greater magnitude than expected and can best be explained by the unique social and cultural dynamics of the three populations surveyed. The risk for Fetal Alcohol problems correlates better with the drinking style of each group than with overall figures for alcohol consumption. This is by no means a new concept in alcohol studies (Bales, 1946), but bears particularly important implications for the epidemiology of the Fetal Alcohol Syndrome.

Since FAS cannot be treated after the fact, but can be prevented completely by education and other measures directed at women in the childbearing years (Russell and Bigler, 1979; Rosett et al., 1981; Sokol and Miller, 1980; Streissguth et al., 1983), the ability to define a subpopulation at high risk has great importance as a public health issue (Little, 1979; Little and Streissguth, 1981). Education and intervention efforts can be targeted with greater effectiveness once these factors have been determined, and existing social constraints might be turned to positive uses in supporting efforts at alcohol abstinence in pregnant women. During the course of the study, it became evident that the issue of fetal alcohol damage gained widespread and enthusiastic interest among health workers and the general population (May and Hymbaugh, 1983), in contrast to the indifferent response often generated by approaches to other alcohol-related problems. Since the Fetal Alcohol Syndrome is the most common severe birth defect in the groups surveyed, any potential preventive measures hold promise for a significant reduction in the tremendous social, financial, and personal burdens caused by this disorder.

ACKNOWLEDGMENTS

This project has been supported by contracts 242–79–0072, 242–79–0081, and 240–81–0002 of the Indian Health Service and the Health Services Administration, and Research Career Award 5 K04 HL00951 of NHLBI.

The authors gratefully acknowledge the assistance of many individuals within the All Indian Pueblo Council and the Indian Health Service, particularly Roland Johnson, Emmanuel Moran, Marlene Hafner, Al Hiat, David Broudy, David Heppel, Ed Little, Joe Sonderleiter, and others. Also special thanks to Kirk Aleck, Ann Streissguth, Lorraine Ration, Nadine Wacondo, and Cindy Self.

REFERENCES

AASE, JON M. 1981. The fetal alcohol syndrome in American Indians: A high risk group. Neurobehav. Toxicol. Teratol. **3**:153–156.

ADAMS, M. S., and J. D. NISWANDER. 1968. Birth weight of North American Indians. Hum. Biol. **40**:226–234.

BALES, R. E. 1946. Cultural differences in the rates of alcoholism. Quart. J. Stud. Alcoh. **6**:480–499.

BENNION, L., and T. K. LI. 1976. Alcohol metabolism in American Indians and Whites. New Engl. J. Med. **294**:9–13.

BROUDY, D. W., and P. A. MAY. 1983. Demographic and epidemiologic transition among the Navajo Indians. Soc. Biol. **30**(1):1–16.

CARR, B., and E. S. LEE. 1978. Navajo tribal mortality: A life table analysis of the leading causes of death. Soc. Biol. **25**:279–287.

CURLEY, R. 1967. Drinking patterns of the Mescalero tribe. Quart. J. stud. Alcoh. **28**(1):116–131.

DAHAENE, P., G. CREPIN, G. DELAHOUSSE, D. QUERLAN, R. WALBAUM, M. TITRAN, and C. SAMAILLE-VILLETTE. 1981. Aspects epidemiologiques du syndrome d'alcoholisme foetal. La Nouvelle Presse Medicale **10**(32):2639–2643.

DEHAENE, P., C. SAMAILLE-VILLETTE, P. SAMAILLE, G. CREPIN, R. WALLAUM, P. DEROUBAX, and A. P. BLANC-GARIN. 1977. Fetal alcohol syndrome in the north of France. Translation from Revue de L'Alcoholisme **23**(3):145–158.

DOZIER, E. P. 1970. The Pueblo Indians of North America. Holt, Rinehart and Winston, New York.

ECKARDT, M. J., T. C. HARFORD, C. T. KAELBER, E. S. PARKER, L. S. ROSENTHAL, R. S. RYBACK, G. S. SALMOIRAGHI, E. VANDERVEEEN, and K. R. WARREN. 1981. Health hazards associated with alcohol consumption. JAMA **246**(6):648–666.

IBER, F. L. 1980. Fetal alcohol syndrome. Nutrit. Today, 4–11.

INDIAN HEALTH SERVICE. 1975. Life table for Indians. Agency memorandum, Washington, D.C.

JESSOR, R., T. GRAVES, R. HANSON, and S. JESSOR. 1968. Society, personality and deviant behavior: A study of tri-ethnic community. Holt, Rinehart and Winston, New York.

JONES, K. L., and D. W. SMITH. 1976. The fetal alcohol syndrome: Clinical delineation. Ann. N.Y. Acad. Sci. **273**:130–137.

JONES, K. L., D. W. SMITH, C. N. ULLELAND, and A. D. STREISSGUTH. 1973. Pattern of malformation in offspring of chronic alcoholic mothers. Lancet **1**:1267–1271.

KLUCKHOLN, C., and D. LEIGHTON. 1962. The Navajo. Doubleday, Garden City, N.Y.

KUNITZ, S. J., and J. E. LEVY. 1981. Navajos. *In* A. Harwood (ed.), Ethnicity and medical care. Harvard University Press, Cambridge, Mass.

LEVY, J. E., and S. J. KUNITZ. 1974. Indian drinking: Navajo practices and Anglo-American theories. Wiley, Interscience, New York.

LITTLE, R. E. 1979. Drinking during pregnancy: Implications for public health. Alcoh. Health Res. World **4**(1):36–42.

———. 1977. Moderate alcohol use during pregnancy and decreased infant birth weight. AJPH **67**(12):1154–1156.

LITTLE, R. E., and A. P. STREISSGUTH. 1981. EFFECTS OF ALCOHOL ON THE FETUS: IMPACT AND PREVENTION. CANAD. MED. ASSOC. J. **125**:159–164.

LONGCLAWS, L., C. BARNES, L. GRIEVE, and R. DUMOFF. 1980. Alcohol and drug use among the Brokenhead Ojibwa. J. Stud. Alcoh. **41**(1):21–36.

MAY, P. A. 1982. Substance abuse and American Indians: Prevalence and susceptibility. Inter. J. Addic. **17**(7):1185–1209.

———. 1982. Susceptibility to substance abuse among American Indians. NIDA Res. Monograph. **41**:35–46.

MAY, P. A., and K. J. HYMBAUGH. 1983. A pilot project on fetal alcohol syndrome for American Indians. Alcoh. Health Res. World **7**:3–9.

NATIONAL CENTER FOR HEALTH STATISTICS. 1976. Standard Pediatric Growth Charts. Government Printing Office, Washington, D.C.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM. 1981. Alcohol and Health, 4th edition. Government Printing Office, Washington, D.C.

OLEGARD, R., K. G. SABEL, M. ARRONSSON, B. SANDIN, P. R. JOHANSOON, C. CARLSON, M. KYLLERMAN, K. IVERSON, and A. HRBEK. 1979. Effects on the child of alcohol abuse during pregnancy. Acta. Paediatr. Scand. Suppl. **275**:112–121.

REED, T., H. KALANT, R. GIBBINS, B. KAPUR, and J. RENKIN. 1976. Alcohol and acetaldehyde metabolism in Caucasians, Chinese and American Indians. Canad. Med. Assoc. J. **115**:851–855.

REIDY, R. 1982. A comparative study of mortality among New Mexico Apache, Navajo, and Pueblo (1969–1980). Unpublished M.A. thesis. University of New Mexico, Albuquerque.

BEST COPY AVAILABLE.

ROSETT, H. L. 1976. Effects of maternal drinking on child development: An introductory review. Ann. N.Y. Acad. Sci. **273**:115–117.

———. 1974. Maternal alcoholism and intellectual development of offspring. Lancet 2:218.

ROSETT, H. L., E. M. OUELLETTE, and L. WEINER. 1976. A pilot prospective study of the fetal alcohol syndrome at the Boston City Hospital, Part I: Maternal drinking. Ann. N.Y. Acad. Sci. **273**:118–122.

ROSETT, H. L., L. WEINER, and K. EDELIN. 1981. Strategies for prevention of fetal alcohol effects. Amer. J. Obstet. Gynec. **57**(1):1–7.

RUSSELL, M., and L. BIGLER. 1979. Screening for alcohol related problems in an outpatient obstetric-gynecologic clinic. Amer. J. Obstet. Gynec. **134**(1):4–12.

SCHAEFFER, J. M. 1981. Firewater myths revisited. J. Stud. Alcoh. **9**:99–117.

SCHROEDER, A. H. 1974. Apache Indians. Garland Publishing, New York.

SMITH, D. W., K. L. JONES, and J. W. MANSON. 1976. Perspectives on the cause and frequency of the fetal alcohol syndrome. Ann. N.Y. Acad. Sci. **273**:138–139.

SOKOL, R. J., and S. I. MILLER. 1980. Identifying the alcohol abusing obstetric/gynecologic patient: A practical approach. Alcoh. Health Res. World. **4**(4):36–40.

STREISSGUTH, A. P. 1977. Maternal drinking and the outcome of pregnancy: Implications for child mental health. Amer. J. Orthopsychiatry **47**(3):422–431.

———. 1980. Introduction: Female alcoholism: Impacts on women and children. *In* M. Galanter (ed.), Currents in alcoholism, Volume VII. Grune & Statton, New York.

STREISSGUTH, A. P., H. M. BARR, D. C. MARTIN, and S. WOODELL. 1978. Effects of social drinking on Apgar scores and neonatal states (abstract). Alcoh. Clin. Exper. Res. **2**:215.

STREISSGUTH, A. P., B. DARBY, H. BARR, J. SMITH, and D. C. MARTIN. 1983. Comparison of drinking and smoking patterns during pregnancy over a six year interval. Amer. J. Obstet. Gynec. **145**(6):716–724.

STREISSGUTH, A. P., C. S. HERMAN, and D. W. SMITH. 1978. Stability of intelligence in the fetal alcohol syndrome: A preliminary report. Alcoh. Clin. Exper. Res. **2**(2):165–170.

STREISSGUTH, A. P., S. LANDESMAN-DWYER, J. C. MARTIN, and D. W. SMITH. 1980. Teratogenic effects of alcohol in human and laboratory animals. Science **209**:353–361.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. 1979. Population estimates and projections. Indian Health Service Memorandum, Office of Program Statistics, November 3. Washington, D.C.

U.S. PUBLIC HEALTH SERVICE. 1978. Indian health trends and services. U.S. Government Printing Office, Washington, D.C.

———. 1979. Selected vital statistics for Indian Health Service Areas and Service Units, 1972–1977. U.S. Government Printing Office, Washington, D.C.

VANWINKLE, N. 1981. Native American suicide in New Mexico: A comparative study 1957–1979. Unpublished M.A. thesis. University of New Mexico, Albuquerque.

WHITTAKER, J. O. 1962. Alcohol and the Standing Rock Sioux Tribe. Quart. J. Stud. Alcoh. **23**:468–479.

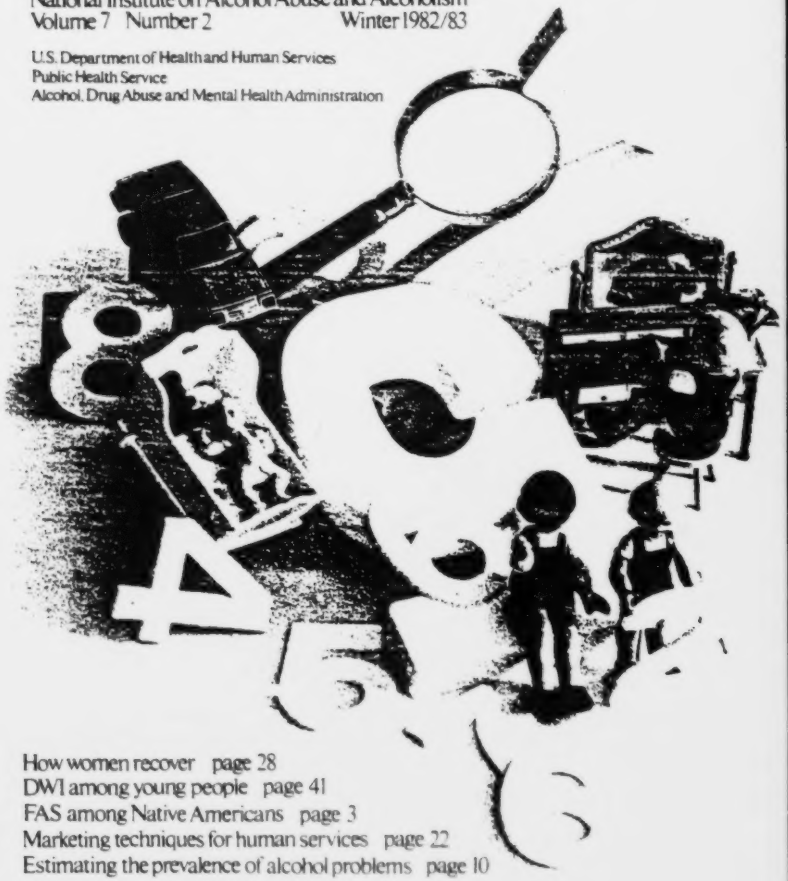
———. 1982. Alcohol and the Standing Rock Sioux Tribe: A twenty year follow-up study. J. Stud. Alcoh. **43**(3):191–200.

BEST COPY AVAILABLE

Alcohol Health & Research World

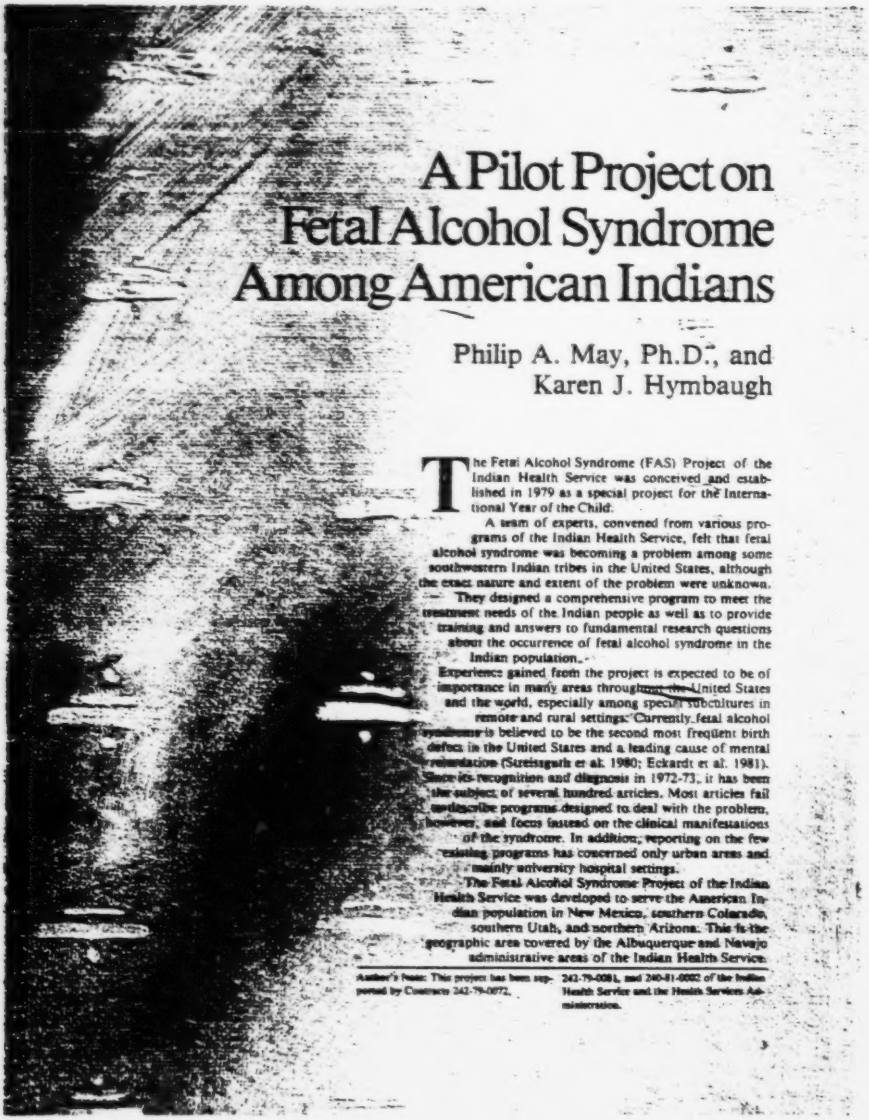
National Institute on Alcohol Abuse and Alcoholism
Volume 7 Number 2 Winter 1982/83

U.S. Department of Health and Human Services
Public Health Service
Alcohol, Drug Abuse and Mental Health Administration



How women recover page 28
DWI among young people page 41
FAS among Native Americans page 3
Marketing techniques for human services page 22
Estimating the prevalence of alcohol problems page 10

200
BEST COPY AVAILABLE



A Pilot Project on Fetal Alcohol Syndrome Among American Indians

Philip A. May, Ph.D., and
Karen J. Hymbaugh

The Fetal Alcohol Syndrome (FAS) Project of the Indian Health Service was conceived and established in 1979 as a special project for the International Year of the Child.

A team of experts, convened from various programs of the Indian Health Service, felt that fetal alcohol syndrome was becoming a problem among some southwestern Indian tribes in the United States, although the exact nature and extent of the problem were unknown. They designed a comprehensive program to meet the treatment needs of the Indian people as well as to provide training and answers to fundamental research questions about the occurrence of fetal alcohol syndrome in the Indian population.

Experience gained from the project is expected to be of importance in many areas throughout the United States and the world, especially among special subcultures in remote and rural settings. Currently fetal alcohol syndrome is believed to be the second most frequent birth defect in the United States and a leading cause of mental retardation (Streissguth et al. 1980; Eckardt et al. 1981). Since its recognition and diagnosis in 1972-73, it has been the subject of several hundred articles. Most articles fail to describe programs designed to deal with the problem, however, and focus instead on the clinical manifestations of the syndrome. In addition, reporting on the few existing programs has concerned only urban areas and mainly university hospital settings.

The Fetal Alcohol Syndrome Project of the Indian Health Service was developed to serve the American Indian population in New Mexico, southern Colorado, southern Utah, and northern Arizona. This is the geographic area covered by the Albuquerque and Navajo administrative areas of the Indian Health Service.

Author's Note: This project has been supported by Contracts 242-79-0072, 242-79-0081, and 240-81-0002 of the Indian Health Service and the Health Services Administration.

BEST COPY AVAILABLE

Indian groups served include the Navajos, Apaches, Pueblos, and Utes. In 1980, about 240,000 Indians lived on 26 reservations in the areas.

The socioeconomic status of the southwestern Indian tribes varies, for they represent cultures in various stages of transition (Kunitz and Levy 1981). Many young Indians are upwardly mobile through recent educational and economic gains, but the majority of the individuals and tribes served have little advanced education and few economic assets. Increased resource development, on reservations and in the Southwest, has wrought drastic changes in the social and cultural systems of these tribes.

The land area on which they live is vast—over 150,000 square miles (figure 1). The Navajo reservation alone is larger than the State of West Virginia. Although most travel can be done by car, a small charter plane is required to reach some outlying areas. Within the Indian Health Service system, 11 hospitals and 10 clinics in various locations serve as contact points for the project.

The project was designed with several objectives. Treatment efforts were to emphasize clinical diagnosis. The purpose of diagnosis was to identify the clinical manifestations of FAS in Indian children, develop a treatment plan, refer children to available resources, and prevent further FAS births (table 1). Training of clinicians, outreach workers, and community groups was to focus on the recognition and prevention of fetal alcohol syndrome. Research efforts were designed to assess the incidence and prevalence of the syndrome among Indian children, determine its etiology, and use this information to develop prevention strategies.

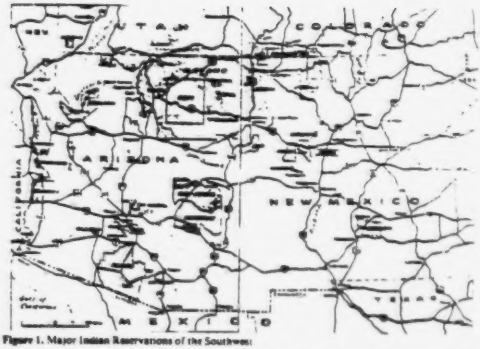


Figure 1. Major Indian Reservations of the Southwest

Staff

The FAS Project staff consists of four regular staff and two consultants: a half time director (Ph.D.), two full-time field coordinators (B.S. and A.A.), a full-time secretary, and two consultant dysmorphologists (M.D.). Teamwork is necessary, as is a thorough knowledge of both the Indian Health Service and the local tribal systems. Two of the staff are Indians from the local area, and all staff have considerable experience in Indian health care on local Indian reservations.

The director oversees all aspects of the project, from training and research to relationships with agencies and tribes and administrative matters. Professional experience in epidemiology, field research, and community health is needed. The director is responsible for much of the training of a variety of individuals, from physicians to outreach workers.

The two field coordinators provide all project services in their assigned geographic area. Training of local outreach workers and citizens is a major duty of the field coordinators. They also coordinate all clinics in their assigned area and keep track of all patients from these clinics. Development of program materials and dissemination of all types of information (pamphlets, posters, articles, and advice) is a constant activity. On one reservation (Navajo) translation of materials into the tribal language has been important, and on all reservations a sensitivity to cultural differences has been vital.

The consultant dysmorphologists, pediatricians who specialize in birth defects and anomalies, are indispensable. In addition to the key role they play in diagnosis of the children, their clinical knowledge has been invaluable. All initial training of clinicians was conducted by the dysmorphologists. The director and field coordinators were apprenticed to the dysmorphologists in these sessions and eventually began to assume most of the responsibility for the training of other target groups. In addition to clinical information, epidemiological, social, and counseling information has been added to the training when appropriate. Although different levels and types of training are used for different groups, the initial core of information was established by the dysmorphologists. The dysmorphologist, with minimal assistance from others, is ultimately responsible for each child's treatment plan.

202

BEST COPY AVAILABLE

Treatment

The clinical phase of the project has had several objectives. The committee of experts who established the FAS project felt that it was important to determine and document if FAS children in the Indian population of the Southwest differed clinically from other FAS children reported on in the literature.

Little information exists on the treatment of FAS children, and therefore, thoughtful formulation of treatment plans was a priority. Each treatment plan was to guide the coordination of all treatment and rehabilitation efforts for that child, and to help the child develop to the fullest potential. Once the treatment plan was formulated, the child was to be referred to the parent organization of the project, the Indian Children's Program. A multidisciplinary team of specialists (table 2) would then provide care and treatment, focusing on working with the child's specific problems and working toward eventual habilitation. Whenever possible, treatment and habilitation were to be carried out near the child's home using local resources.

The clinics were conceived as providing a unique opportunity to work with the mothers of these children. Ideally, the mothers, parents, or guardians would attend the clinics with their children, where they would be counseled regarding future pregnancies and care of the existing FAS children. The clinics also were seen as a way to provide specific, on-site training for local clinicians in the diagnosis of fetal alcohol syndrome. Since the diagnosis is a complex and multivariate one, firsthand experience under the supervision of experienced persons was considered vital for local clinicians.

The referral system. The referral system has been critical to the project. Because the area served is vast, the system has to be well conceived and dynamic. As shown in figure 2, a suggested pattern or chain of referrals has been set up that begins with referral in the local community and ends with treatment of the child.

A variety of informative materials have been developed by project staff as aids in referral and other areas of activity. Two Indian-oriented pamphlets were designed to inform the public about alcohol damage to the unborn. One is simple for the less educated; the other is more detailed for those with at least a high school education. Another pamphlet for health personnel describes the services of the FAS Project. Four posters have been used extensively. They relay the simple idea that alcohol can damage unborn babies, by means of themes and motifs from local Indian cultures.

Identification of children with problems is initially made in local communities, clinics, and hospitals. Then referral usually is made to one of four designated professionals at each clinic or hospital service unit—generally physicians (pediatricians or general medical officers) or nurses (clinic supervisors or public health nurses)—using forms with a checklist of the features of fetal alcohol syndrome. The professionals designated to receive referrals have exhibited a particular interest in FAS and have been trained through lectures and clinics by a consultant dysmorphologist from the project. The professionals make tentative diagnoses, help set up clinics, and ensure clinic attendance.

Clinics are generally scheduled when a minimum of four suspected cases of FAS have been identified in a particular location. They are held in the local facilities (hospital or clinic), with the help of a consultant dysmorphologist and one or more FAS Project staff. After chart review, discussion, and 1/2 to 1 hour spent with the patient, a final diagnosis is made, and a specific treatment plan is completed.

In the initial planning of the project, the clinics were not named. One FAS staff member, searching for an accurate, yet sensitive, way to refer to the clinics, began calling them simply "developmental clinics." This name has proved useful and has been consistently used by project and local staff to describe all of our clinics. It is also accurate, for a variety of patients with

Table 1. Goals of the Fetal Alcohol Syndrome Project

Training in the recognition and prevention of FAS and all prenatal alcohol damage. Target groups include—

- Clinicians
- Outreach workers—Public health nurses, alcohol counselors, Headstart teachers, community health representatives, etc.
- Community groups—Tribal councils, schools, local units of government, etc.

Clinical diagnosis of developmentally disabled children who are suspected of having FAS. The purpose of this diagnosis is—

- To determine the clinical manifestations of FAS in Indian children
- To provide a treatment plan that can be carried out to promote each child's optimum development
- To refer children to the Indian Children's Program or other resources for needed services
- To prevent further FAS children

Research to better define the nature of alcohol damage to unborn Indian babies. Specifically addressed are—

- Incidence and prevalence
- Etiology (medical and social)
- Prevention strategies

Table 2. Indian Children's Program Multidisciplinary Team

Clinical psychologists
Developmental psychologist
Speech therapists
Developmental pediatrician
Occupational therapists
Physical therapists
Art therapist
Vocational rehabilitation therapist
Educational diagnosticians
Social workers
Recreational therapist
Child psychiatrist

BEST COPY AVAILABLE

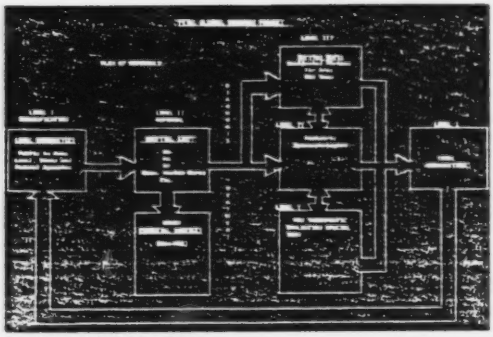


Figure 2. Fetal Alcohol Syndrome Project

diagnoses in addition to FAS and alcohol-related ones have been seen. Regardless of the ultimate diagnosis, any child needing further special treatment or attention receives a treatment plan.

All clinics are directed by a dysmorphologist, and in each a team approach is used. Project staff and local clinic personnel perform support duties such as taking basic measurements (length, weight, and head circumference), giving a Denver Developmental Screening Test, taking a brief medical and social history, and collecting pictures for files. Approximately 1 hour is spent with each child. Several people work together in the initial screening, and one, two, or three staff people generally are present during the dysmorphologist's examination. The main focus of the clinic is obviously on the needs of the child, but an equally important part of each clinic is the training of staff. While the FAS staff learns more from the local staff, about local conditions and patients, they teach the local clinicians some of the finer and more subtle points of the clinical evaluation and habilitation of FAS cases and other birth defects and developmental disabilities. Teaching further cements the bond between project staff and local clinicians.

When the examination summary and treatment plan are typed, copies are transmitted to the child's chart at the local service unit. Copies are also retained by the FAS Project staff and presented to the Indian Children's Program and other appropriate treatment agencies and personnel. Treatment and evaluation is coordinated by the Indian Children's Program, using a multidisciplinary team. The team provides the needed services to the child, refers the child to appropriate resources if they are not available within the team, and teaches local people—both lay and professional—the special techniques needed to care for the child. All treatment is carried out in the local community whenever possible.

From initial referral to followup, the cooperation of various types of professionals and laymen is vital. It is imperative that some flexibility and variability be allowed in the referral system to assure that the particular needs, conditions, and circumstances of the local clinics and people involved are taken into consideration. Project needs must be met in a manner that does not interfere with the work of the local clinic.

It has been vital that the FAS Project serve as the ultimate coordinator and assume ultimate responsibility for treatment of the children. A particular advantage has been the sharing of research data and findings, both from the project and from the literature, with all participants in the referral system.

Clinics. From the first clinic in March 1980 to the end of the project on March 3, 1982, 22 clinics were held in 16 different locations (table 3). More are planned for the future, but await funding.

The average number of children seen per day is 9 or 10. In addition to those recorded in table 3, a number of other children were seen briefly at these clinics for other reasons, such as being siblings of suspected FAS children.

The breakdown of diagnoses indicates that 28.9 percent of all children seen in clinics had the full fetal alcohol syndrome, 15.4 percent experienced a milder degree of damage or fetal alcohol effect, and in another 6.1 percent, findings were "suspicious." For a diagnosis of fetal alcohol syndrome to be made, specific criteria must be met: (1) significant prenatal and postnatal growth deficit, (2) mental deficit, (3) facial dysmorphia, (4) physical abnormalities, and (5) documentation of maternal alcoholism. A diagnosis of fetal alcohol effect (FAE) indicates a milder form of prenatal alcohol damage in which the child has virtually all of the features of fetal alcohol syndrome but in less severe form. A "suspicious" diagnosis denotes that the child meets many of the criteria for fetal alcohol effect, except for insufficient documentation of an abusive maternal drinking history. In general, all FAS diagnostic "labels" are applied conservatively and sensitively, with the major focus being on future therapy.

Philip A. May, Ph.D., is a consultant to the Indian Children's Program of the Indian Health Service and associate professor of sociology at the University of New Mexico. He formerly was director of the FAS project of the Indian Children's Program. Karen Hymbaugh is a project analyst with the National Council of Alcoholism DWI Offenders Screening Program in Albuquerque, New Mexico, and a consultant to the Indian Children's Program of the Indian Health Service. She formerly was Albuquerque area coordinator for the FAS project.

BEST COPY AVAILABLE

In general, the pattern of malformations found in the different Indian groups is quite consistent with that found among individuals of other ethnic groups (Aase 1981).

The remaining 50.4 percent of the children were diagnosed as normal or as having another type of birth defect or anomaly. Other diagnoses included Down's syndrome, hypoparathyroidism, fetal hydantoin syndrome, and Noonan's syndrome. Other types of developmental problems were referred to the clinics so that the dysmorphology services could be used. Some of these referrals were made for anomalies similar in appearance to FAS, but others were totally unrelated and were made simply because the service was needed.

The clinics have successfully provided needed diagnostic services for 230 children. They have been well attended, indicating the success of the referral system. The finding that 44.3 percent of the children referred are definitely suffering from some degree of prenatal alcohol damage is another indicator of a successful referral system. The clinics also seem to have helped create and maintain an interest in a variety of developmental disabilities. Providing an underserved area with a needed specialty has been very gratifying to all.

Training

The training of clinicians and outreach workers primarily was designed to aid them in the referral of suspect children for diagnosis and treatment and to use their knowledge in preventive counseling with clients. Major hopes for prevention, however, were focused on the community training sessions involving tribal councils, schools, and local government units. Since fetal alcohol syndrome is a preventable birth defect, educating people of all ages in the community about FAS was considered vital. If people could be made aware that alcohol causes developmental defects, primary prevention would be possible.

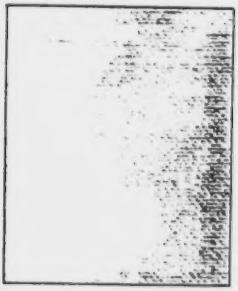
From the beginning of training in January 1980 to March 3, 1982, 232 training sessions were held. In these sessions, 11,123 people were trained by three FAS project staff members and two consultant dysmorphologists (table 4). Of the 11,123 persons trained, 9.3 percent (1,033) were clinicians, 26.7 percent (2,978) were outreach workers, and 63.9 percent (7,112) were community members, primarily students. The average number of people trained per session was 48.

Participating physicians, nurses, pharmacists, and physician assistants generally receive 2 to 2.4 hours of continuing education credits. Community training sessions are less detailed than clinical sessions and rely more heavily on films and discussion than on lecture. In remote parts of the Navajo reservation, sessions often are conducted in the Navajo language through a community interpreter or the Navajo field coordinator. Community sessions are uniformly well received by young and old and do not meet with the resistance generally associated with alcohol-related presentations. In fact, the FAS presentation usually allows for discussion of other, normally controversial alcohol-related topics and issues in a constructive and relaxed atmosphere.

In addition to formal training sessions, posters and pamphlets designed by the program staff increase exposure to fetal alcohol syndrome information. Approximately 7,000 posters and 55,000 pamphlets have been distributed. Films have been important media for the program. In the second year of the project, 40 copies of four different training films on FAS have been continuously on loan to interested parties, such as parent-teacher groups, prenatal classes, health organizations, and schools.

Other materials designed by the program staff that have been widely distributed include a bibliography on fetal alcohol syndrome and related issues; a resource guide listing films, slides, posters, pamphlets, and other FAS materials; and a training guide. All materials have been distributed among national as well as local Indian groups to assist people in starting their own information sessions, campaigns, and systems.

The training sessions and educational materials continue to be enthusiastically received.



BEST COPY AVAILABLE

Research

Research efforts were designed to expand knowledge about fetal alcohol syndrome among Indians. At present, the literature on the incidence and prevalence of fetal alcohol syndrome is very scarce. Estimates of incidence exist only for the United States (Streissguth et al. 1980), Sweden (Olegard et al. 1979), and France (Dehaene 1977). In most cases the estimates provided are only rough; detailed, systematic prevalence studies are needed. No reliable estimate exists for Indians (see Aase 1981). Specific goals of the project were to establish incidence and prevalence figures for the entire population and for individual tribes, to understand the etiological factors involved in the development of fetal alcohol syndrome, and to use this knowledge to devise prevention strategies.

The initial research results, although still incomplete, show that the incidence of fetal alcohol syndrome varies among reservations. On some, no fetal alcohol children have been found, while on others there are children with severe problems. The wide variation in patterns of drinking and alcohol-related problems among the different tribes has been described by Levy and Kunitz (1974) in the social science/epidemiological literature on Indians and alcohol use. Tribes with a loose, band-level social organization tend to have a higher incidence of alcohol-related problems than do those with a strict, highly structured tribal organization. In general, FAS distribution follows this pattern, with the more highly structured tribes having the fewest drinking mothers and lowest incidence of fetal alcohol damage (May, in press). The incidence of FAS among southwestern Indians may be higher than that reported in the United States generally. One out of every 1,500 to 2,000 babies born in the U.S. is believed to have FAS, while the incidence of other adverse consequences during pregnancy is estimated to be 20 times that rate, according to Assistant Secretary for Health Edward N. Brandt, Jr., M.D., in Congressional testimony in September 1982. Some of the reservations in the project have a significantly higher incidence of FAS than the general United States population, which cancels out the effect of lower incidence reservations and, therefore, makes the overall incidence slightly higher.

A research finding of major importance is the prevalence of multiple FAS or FAE children being born to one mother. Among the mothers with affected children, 22.6 percent have produced more than one damaged child (average 2.36 per multiple producing mother). This appears to be very unusual, for little documentation of this exists in the literature on the general population. Only one case of FAS-affected twins has been found among mothers in our project. It is important to calculate incidence in two ways: the proportion of damaged babies produced per all births; and the proportion of all mothers producing alcohol-damaged babies. These figures will provide more specific indicators of risk and better insight for prevention.

Ostracism of the drinking mother may play a role in the production of multiple FAS babies. In many southwestern tribes, few women drink. Alcoholic women therefore are not tolerated and are frequently left out of regular social interaction. The consequence is almost total lack of social control over their behavior. These women generally migrate to border towns where their only friends and associates are other alcoholics—a setting where there is little stigma attached to the production of multiple FAS children.

Other data indicate that mothers who produce alcohol-damaged children are at high risk in the social sense. A high percentage of the FAS children are in foster placement (see table 3), a high percentage of the mothers are deceased (21 percent), and most mothers have extensive clinic records for alcohol-related problems such as accidents, trauma, and alcohol withdrawal.

Table 3. Diagnosis of patients in developmental clinics by sex and foster placement, March 1980 to March 3, 1982.

Diagnosis	Total	Percent	Male	Female	Foster Placement	Percent
FAS	66	28.9	35	31	48	(72)
FAE	35	15.4	24	11	26	(74)
Suspicious	14	6.1	5	9	10	(71)
Other/Not FAS	113	50.4	66	47	64	(57)
Total	228	100	130	98	98	(85)

Note: 24 clinic days; average 9.58 patients per clinic day.

Table 4. People trained by the Fetal Alcohol Syndrome Project by occupation, January 1980-March 3, 1982.

Occupation	Number	Percent
Clinicians	1,033	9.3
Outreach workers	2,978	26.7
Community persons	7,112	63.9
Students (h.s. or below)	(6,322)	(56.8)
Others	(790)	(7.1)
	11,123	100

Note: Average (mean) per session = 47.9 Clinical and outreach worker sessions are generally smaller than this average.

206

BEST COPY AVAILABLE

Conclusion

This paper describes a comprehensive program designed to study and deal with the problem of fetal alcohol syndrome among Indians in the southwestern United States. Training and education, clinical diagnosis and treatment, and research and prevention are all components of this project. Each part of the project has been designed to allow for a variety of complementary efforts.

The project depends highly on interaction and cooperation among community and medical interests. Although the project described here can be used elsewhere with success, it must be innovatively, flexibly, and humanistically adapted to local circumstances. In other words, this system is a guide that directs and focuses efforts. It can and should be varied from time to time to meet the needs of local health providers, communities, and other cooperating interests.

The services of such a project can easily be offered to communities in a sensitive and nonthreatening way. These services seem to help build a relationship that spans the gap between the project and local concerns and creates a new awareness of FAS and of developmental disabilities in general.

It is unlikely that a program omitting any of the strong training, clinical, or research effort would be nearly as effective. Results from the program serve as evidence that it works. A vast number of people have been trained. Many children have been referred and diagnosed appropriately. And finally, the research effort has provided new, exciting, and accurate information that will aid in future understanding, intervention, and prevention.

References

BASE, J. M. The fetal alcohol syndrome in American Indians: A high risk group. *Neurobehavioral Toxicology and Teratology* 3:153-156, 1981.

DAHAENE, P., SAMAILLE-VILLETTE, C., SAMAILLE, P., CREPIN, G., WALBAUM, R., DEROUBAIX, P., and BLANC-GARIN, A.P. Le syndrome d'alcoolisme foetal dans le nord de la France (Fetal alcohol syndrome in the North of France). *Revue de L'Alcoolisme* 23(3):145-158, 1977.

ECKARDT, M.J., HARFORD, T.C., KAELBER, C.T., PARKER, E.S., ROSENTHAL, L.S., RYBACK, R.S., SALMORAGHI, G.C., VANDERVEEN, E., and WARREN, K.R. Health hazards associated with alcohol consumption. *Journal of the American Medical Association* 246(6):648-666, 1981.

FRIED, P.A., WATKINSON, B., GRANT, A., and KNIGHTS, R.M. Changing patterns of soft drug use prior to and during pregnancy: A prospective study. *Drug and Alcohol Dependence* 6(5):323-343, 1980.

HOOK, E.B. Changes in tobacco smoking and ingestion of alcohol and caffeinated beverages during early pregnancy: Are these consequences, in part, of feto-protective mechanisms diminishing maternal exposure to embryotoxins? In: Kelly, S. *Birth Defects: Risks and Consequences*. New York: Academic Press, 1976.

JONES, K.L., SMITH, D.W., ULLELAND, C.N., and STREISSGUTH, A.P. Pattern of malformation in offspring of chronic alcoholic mothers. *Lancet* 7815(1):1267-1271, 1973.

KUNITZ, S.J., and LEVY, J.E. Navajos. In: Harwood, A., ed. *Ethnicity and Medical Care*. Cambridge, MA: Harvard University Press, 1981.

LEVY, J.E., and KUNITZ, S.J. *Indian Drinking: Navajo Practices and Anglo-American Theories*. New York: Wiley Interscience, 1974.

LITTLE, R.E., SCHULTZ, F.A., and MANDELL, W. Drinking during pregnancy. *Journal of Studies on Alcohol* 37(3):375-379, 1976.

LITTLE, R.E., and STREISSGUTH, A.P. Drinking during pregnancy in alcoholic women. *Alcoholism: Clinical and Experimental Research* 2(2):179-183, 1978.

LITTLE, R.E., STREISSGUTH, A.P., and GUZINSKI, G.M. Prevention of fetal alcohol syndrome: A model program. *Alcoholism: Clinical and Experimental Research* 4(2):185-198, 1980.

MAY, P.A. Substance abuse and American Indians: Prevalence and susceptibility. *International Journal of the Addictions*, in press.

OLEGARD, R., SABEL, K.G., ARONSSON, M., SANDIN, B., JOHANSSON, P.R., CARLSSON, C., KYLLERMAN, M., IVERSON, K., and HRBEK, A. Effects on the child of alcohol abuse during pregnancy. *Acta Paediatrica Scandinavica* 275(Suppl.):112-121, 1979.

ROBERT, M.L., WEINER, L., and EDELIN, K.C. Strategies for prevention of fetal alcohol effects. *Obstetrics and Gynecology* 57(1):1-6, 1981.

RUSSELL, M., and BIGLER, L. Screening for alcohol related problems in an outpatient obstetric-gynecologic clinic. *American Journal of Obstetrics and Gynecology* 134(1):4-12, 1979.

SOKOL, R.J., and MILLER, S.I. Identifying the alcohol-abusing obstetric/gynecologic patient: A practical approach. *Alcohol Health and Research World* 4(4):36-40, 1980.

STREISSGUTH, A.P. Maternal drinking and the outcome of pregnancy: Implications for child mental health. *American Journal of Orthopsychiatry* 47(3):422-431, 1977.

STREISSGUTH, A.P., LANDESMAN-DWYER, S., MARTIN, J.C., and SMITH, D.W. Teratogenic effects of alcohol in human and laboratory animals. *Science* 209(4454):353-361, 1980.

STREISSGUTH, A.P., MARTIN, D.C., MARTIN, J.C., and BARR, H.M. "Alcohol and Nicotine Ingestion in Pregnant Women." Paper presented at the meeting of the Western Psychological Association, Seattle, 1977.

BEST COPY AVAILABLE

Amer. J. Orthopsychiat. 44(1), January 1974

ADOLESCENT SUICIDE AT AN INDIAN RESERVATION

Larry H. Dizmang, M.D., Jane Watson, M.S.W., Philip A. May, M.A., John Bopp, M.S.W.

The backgrounds of ten American Indians who committed suicide before the age of twenty-five are compared statistically with a matched control group from the same tribe. The contrast is significant in at least six variables that point to the greater individual and familial disruption experienced by the suicidal youths. Suggestions for treatment and prevention based on the experience of this tribe are offered.

The Shoshone and the Bannocks (grouped linguistically as the Shoshonean) who live in Fort Hall, Idaho, have their origins in at least seven localities, all within the region now called Southeast Idaho and Northern Utah. Both tribes adapted quite similarly to the environment and therefore exhibited no great variations in life styles.

The ecology of the region, at least prior to the greater mobility some bands obtained with the horse, permitted only small groups of people to hunt, gather and camp together. The camps consisted of two to forty people, depending on the season and the availability of small game and gatherable foodstuff. Each camp was composed of bilaterally extended kinship groupings and was extremely fluid; members were free to break off from the group, join another, or go their own ways. Often the reason for departure involved the desire to try a new area of land, to stay with other family members, or a dispute with another camp member. The choice to leave was always individual—that is, there was no ordered or inherited system of leadership that had power over these decisions.[6]

Presented in a similar version at a meeting of the American Psychiatric Association, May 1970. The study was undertaken as intramural research for Center for Studies of Suicide Prevention of NIMH, with which the first three authors were associated.

Authors are: in private practice in Annapolis, Md. (Dizmang); at Department of Social Services, Adams County, Colorado (Watson); Staff Sociologist, Community Mental Health Program, U.S. Public Health Service, Pine Ridge, S.D. (May); and Service Unit Director, Indian Health Service, Fort Hall, Idaho (Bopp).

208 BEST COPY AVAILABLE

Leadership was a matter of proving oneself, of being accepted by the group.[5] Individuals who disagreed with the camp leader simply moved away. Leadership beyond the camp was limited to specific and infrequent communal occasions such as a hunt or religious ceremony.

If a segment of the group departed, it was not always an intact nuclear family. Sometimes, if a man or woman took a new mate and went to live with the spouse's family, children by the former marriage were left with the original group.[2] The responsibility of raising children was often shared with an older sister, an aunt, or a grandmother.[3] It was common practice for children to be raised by several women, which was particularly adaptive in a culture that had to provide emotional and physical protection against loss of the caretaker by early death. It provided the child, from birth, with several "mothers" with whom he had close emotional and kinship ties.

Emotional self-sufficiency at an early age was stressed. Just as a group of mother figures had been culturally evolved to protect the child against early loss, it was also necessary to create cultural defenses to protect the individual from later loss and to insure a high degree of individual autonomy. Any form of dependence on one individual was too risky in a culture that experienced frequent loss of life. The child learned not to verbalize his needs for love, loyalty, and trust. It was expected that he would take for granted that these would be given him as needed, unspoken, and unasked for. He was to endure pain. External aggression, directed towards an outside group of enemies, was the only sanctioned form of emotional expression.[4] Internalization of these values produced adults who were able to withstand frequent loss and separation.

The Shoshonean life style was not finally disrupted until the creation of the reservation in 1869. The policy of the federal government violated Indian concepts of ownership and leadership. To the Shoshonean the Earth was a maternal, life-giving entity from which one could procure sustenance; use never implied ownership. The concept of tribal use was always far stronger than that of individual ownership.[5]

In 1887 it was stipulated that the lands of the reservation were to be parceled out in 40–160 acre plots to each Indian. Whether intentionally or not, the division of land in this manner served to break up the extended family group.[2] Although family groups were separated, child rearing patterns and other traditional social relationships did not change commensurately.

By the early 1800s the Shoshonean were involved in trade with whites. The acquisition by the Indians of metal implements, liquor, and food initiated the beginning of dependence not only on the trade items, but also on the traders. As their source of food and shelter was being decimated, the Shoshonean became reliant upon the white man for their livelihood. This dependence was finally institutionalized by the creation of the reservation system.

Confinement to the reservation meant more than just an end to a nomadic life style. It eroded the economic and traditional structure that had given the male his role and his self-esteem in the culture, and brought on a sense of powerlessness. The male derived his status from his ability to direct the family's moves to areas where game and food-

stuffs were most available. In addition, the male was responsible for hunting small game, a difficult and highly demanding skill. The reservation boundaries limited the area in which to move and, because the game was depleted, food now had to be obtained from the government. The skills of the male were suddenly obsolete and his role within the family group and culture lost all meaning. Thus the matrix for the present social and cultural chaos was created. It is within this cultural matrix that the present conditions of the reservation at Fort Hall have developed.[1] There now exists a situation that exhibits much social and family disorganization. Not only is suicide a significant problem but many other forms of self-destructive behavior are also common, such as alcoholism, accidents, and homicide (often victim-precipitated).

The overall suicide rate for the seven-year period of study at Fort Hall was 98/100,000. This paper will focus on completed suicides on the reservation among individuals below the age of 25. This population was singled out for study because this group accounts for more than one-half of the total suicides! This is in sharp contrast to the non-Indian population in the United States, among whom the suicide rate is lowest among adolescents and rises steadily with age.

SAMPLING

The experimental group in this study consists of all known unequivocal suicides at Fort Hall of Indians under the age of 25, from 1961 through 1968. The suicide sample consists of ten individuals ranging in age from 15 to 24. In addition, there were seven other completed suicides that occurred within this same time period, but because of the unusually high incidence of suicide among the younger age group, only the subjects under the age of 25 were examined in this study. Undoubtedly, there was a significantly larger group of suicides during this period of time than was recorded; since a number of individuals in this age range died violently, many of these deaths may have been either suicidal in intent or victim-precipitated homicide. This study includes only those cases where suicide was clearly and unquestionably the cause of death.

The control group was chosen by stratifying the sample on the basis of the following variables: 1) age; 2) sex; 3) degree of Indian blood (within one-eighth degree)*; and 4) no known suicidal attempt by the control member or anyone within his nuclear family or household prior to the death date of the matched suicide subject.** A control group consisting of four individuals matched by the above variables was selected for each of the ten suicides.

The actual selection process was accomplished by the use of the random-quota method. The Tribal Census of 1960 was obtained and for every control group a random starting point was selected. From this random point selec-

* In one case, it was not possible to select a fourth member for a control group which matched the suicide in degree of blood. A control was selected who was one-fourth degree lower in S-B blood but who matched the suicide in degree of Indian blood.

** If a control member had experienced a suicide or an attempted suicide in his nuclear family or household, or had attempted himself, he was excluded from the control group and a replacement was selected. Deletions occurred five times throughout the selection of controls.

BEST COPY AVAILABLE

tion of the four members in each control group was made by going down the Tribal Roll (which is arranged alphabetically according to heads of households) and selecting the first four individuals who matched the criteria. Thus the ten suicides were matched against 40 control subjects.

PROCEDURE

A data survey form was designed to collect information on each subject. The final data analysis sheet is a 104-item survey of each subject's background as well as the background of his family. This survey form is divided into five categories: family background, health and clinic record, law and order record, educational background, and personal data.

For each suicide and control in the sample, a survey form was filled out as completely as possible from existing records, including the Indian Health Service Clinic; the Bureau of Indian Affairs police records, social service, employment and education records; and from the local schools attended by the subjects. In addition, one member (J.W.) of the research team lived for a period of fourteen months on the reservation and collected much personal data from interviews with individuals and family members when the data did not exist in the official records.

After initial examination of the data sheets, some of the variables were discarded because of insufficient data. No item was used in the statistical analysis where information was lacking on more than five control subjects. In the final analysis, 35 variables were examined in relationship to their distribution, standard deviation, means, and variation. A t-test (one-tailed) was run on the 35 variables comparing the characteristics of the suicide group with those of the control group. Six items proved to be statistically significant to at least the .025 level.

RESULTS

The first significant variable indicates that 70% of the subjects in the suicide group had more than one significant caretaker before the age of fifteen, as compared to 15% of the control group (significant to the .005 level, $t=2.771$; $df=48$).* In other words, the subjects in the suicide group were frequently cared for by more than one individual in their developing years, while most control group subjects were cared for by one caretaker.

A second finding indicates that 40% of the primary caretakers of the suicidal group had five or more arrests, as compared with 7.5% of the controls (significant to the .005 level, $t=2.747$; $df=48$).

As indicated by a third statistic, 50% of the suicide group experienced two or more losses by desertion or divorce, while 10% of the control group had the same experience. The subjects in the suicide group suffered significantly more loss by desertion and divorce than did the controls (significant to the .005 level, $t=3.438$; $df=48$).

The remaining variables consider the subject directly, rather than his family. Among the suicide subjects, 80% had one or more arrests in the twelve-month period preceding his death, while 27.5% of the controls were arrested one or more times in a similar twelve-month period

* Significant caretaker is defined as anyone who has had prime responsibility for the subject for a span of six months or more in the subject's first fifteen years.

BEST COPY AVAILABLE

(significance at the .005 level, t=3.324; df=48).

Other variables that also concerned arrest records were tested, and it was found that the total number of arrests did not distinguish the control and the suicide groups. However, there was a significance found in the age of first arrests. By the age of fifteen, 70% of the suicides had been arrested, as compared to 20% of the controls (significance to the .01 level, t=2.583; df=48). Thus, it is *not* the number of arrests that separates the two groups, but the timing of the arrests. The suicidal youths suffered *both* more arrests in the year of their suicide and were arrested at a significantly earlier age.**

The final statistic for discussion concerns Indian Boarding School. Among the suicidal youths, 60% were found to have attended boarding school by or before the ninth grade, as compared to 27.5% of the controls (significance to the .025 level; t=2.088; df=48). In addition, the total percentage of the suicide subjects who attended boarding school was 70%. This was more than twice the percentage of controls (30%).

DISCUSSION

It does not take any detailed or intricate analysis to look at the results and realize that all of the factors that are statistically significant point to a single common denominator. The level of significance of the data only serves to underscore what is clinically obvious when one visits the reservation. The family and social chaos that the suicide group experienced was certainly relative, since almost no one on the reservation can escape the reality of his history and the cultural disintegration that has taken place in the last 75 years. There can be little doubt that the individuals who committed suicide experienced far more individual disruption in the early formative years of their lives than did the controls. The internal unrest of the individuals who committed suicide was manifested by the earlier age of first arrests and the larger number of arrests the year prior to suicide. The data concerning the significant caretakers is only a sketchy outline of some of the early loss, desertion, and insecurity these children must have experienced.

There was one interesting phenomenon that seemed to be an additional factor in accounting for the increased number of caretakers of some of the suicidal individuals. The old traditional patterns of child rearing in an extended family still have some influence on present customs. In the early days, mother, grandmother, aunt, and older sister were usually part of the caretaking system for the children, and they lived in the same band. These individuals are still felt to be part of the caretaking system of children but now they often live many miles apart. When mother raises the child for the first couple of years of his life and then shifts the caretaking responsibility to grandmother because of another child, etc., grandmother is a relative stranger to the child. The child may then experience one or more early "losses," even though a particular nuclear family may be relatively intact. Thus, a culturally-evolved mechanism with high adaptive qualities becomes a serious problem in a new context.

There is a need to offer suggestions on how to remedy the situation, and yet

** Arrests for the controls were considered only if they occurred prior to the date of suicide of the youth with whom they were matched.

BEST COPY AVAILABLE

the suggestions seem painfully obvious. One cannot undo the trauma of history overnight in terms of its present impact upon the individual or the collective lives of a people. A simple change or changes in federal policy will not remedy the situation. Additionally, there are a number of advocates of different and conflicting policies, which only serves to increase the confusion.

It is accurate but insufficient for the Indians to blame many of their problems on the white man at this point. Just as an individual in psychotherapy may have had a "bad mother" on whom he can blame his present trouble, it is only at the point he is able to "work through" the past traumatic experiences that he becomes able to stand on his own and deal with current reality more effectively. Once the individual or cultural pattern has been set it becomes the problem of the individual or cultural group to work through those problems that were forced upon them at a point in their existence where they were powerless to alter the course of events. The Shoshone-Bannock Tribes have begun this task.

Since the initial NIMH consultation in 1967 there have been some important changes on the reservation. It was clear that there was a significant group of individuals who were concerned about suicide as an important part of the overall problem. The need was expressed by the Tribes for help with the suicide problem and, after consultation, a recommendation was made for the various agencies involved, including the Tribes, to develop a medical holding facility on the reservation. The adolescents and young adults of the Tribes, when picked up by the police for intoxicated or disruptive behavior, would be returned to the reservation and treated medically, instead of being put in the white man's jail.

The data presented supports the initial impression that those individuals showing arrest at an early age and those individuals with a large number of arrests the year prior to the suicide were also the ones most likely eventually to commit suicide. The majority of arrests prior to the suicide were for intoxication, glue sniffing, and rowdy, aggressive behavior, and not for serious crimes. It was felt that if these individuals could be treated by medical rather than legal means, there was hope of identifying those in the most "psychological trouble." By having them returned to the reservation, they could be seen by the Public Health Service physician and the social worker immediately, where it would be possible to screen them carefully. In those cases where it seemed warranted, a follow-up plan was employed.

Currently, two years later, there is a medical holding facility on the reservation that is run by the Tribal Business Council and staffed primarily by volunteers from the Tribes, who take turns being on call in order to respond to crises as they occur. It is far too early to make any generalizations, but in the last eighteen months, and since the time this facility was in the active planning stages, there has been only one suicide—an individual over the age of 30 who would not normally have been seen at the holding facility under present circumstances. There have not been, in the last eighteen months, any suicides in the age group for which the holding facility was primarily designed. According to the experience of the previous seven years, two or three suicides below the age of 25 would have been expected during this period of time. Again, we do not want

to draw any conclusions from this observation, as it will take much more time before the effectiveness of this facility can be evaluated. We think the major point of importance is that the Tribes have made significant although often painful efforts to begin to pull themselves together and to begin to deal with the tragedy that they have experienced. They have shown that they do have the capacity to come together as a group to face their difficulties and to work actively towards a solution that does not primarily depend upon the federal or local governments, but rather upon their own people and their own resources. This, to us, is a remarkable show of strength on their part and not only a clear will to live but a will to pick up the pieces and once more become a group with an identity of their own and of which they can be proud.

CONCLUSION

The data presented clearly indicate statistically significant differences between individuals who commit suicide and the control group. The subjects in the suicide group were frequently cared for by more than one individual in their developing years, while control subjects were almost always cared for by a single individual. The primary caretakers of the suicide group had significantly more arrests during the time they were the caretakers of the subjects. The suicide group also experienced many more losses by desertion or divorce than did the control group.

The individuals who committed suicide were arrested more times the year prior to their suicide than were the controls, although the lifetime number of arrests did not distinguish the control and the suicide group. Those who committed suicide were arrested at a significantly earlier age than those in the control group. Many of the completed suicides were sent off to boarding school at a significantly earlier age than were the control group, and they were also sent more frequently to boarding school for some period of their life than were the controls. All of the data point to a chaotic and unstable childhood in those who completed suicide, compared to the controls.

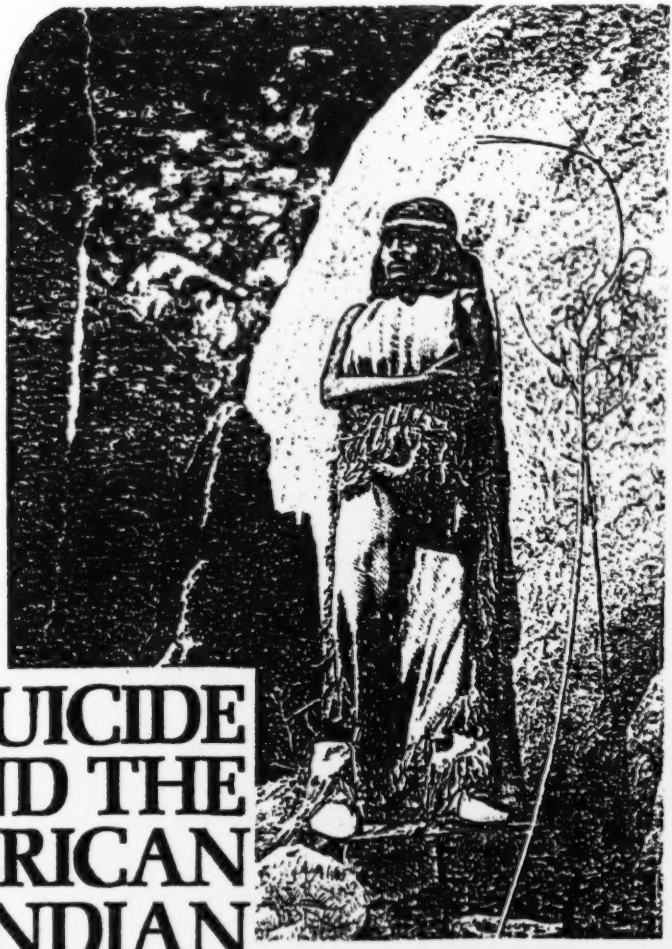
This study only serves to underline what is already clinically known by those individuals who have spent time with any tribe of American Indians whose culturally evolved ways of relating to the world have been significantly disrupted by the white man's intrusion, resulting in cultural and family disorganization. There is no simple solution and it is impossible to undo the reality of the past. Every tribe must work out its own individual solution in order to regain some sense of identity and pride that "I am an Indian" and, in the case of Fort Hall, that "my father was a Bannock" or "my father was a Shoshone."

REFERENCES

1. DIZMANG, L. 1968. Observations on Suicidal Behavior Among Shoshone-Bannock Indians. Presented at the first annual National Conference on Suicidology, Chicago.
2. LILJEBLAD, S. 1968. Some Observations on the Fort Hall Indian Reservation. Unpublished.
3. LILJEBLAD, S. 1969. (Professor of Anthropology, Idaho State University, Pocatello, Idaho.) Personal communication.
4. SKINNER, M. 1959. Some Educational Factors in Health Program Planning for the Shoshone-Bannock Tribes. Unpublished.
5. STEWARD, J. 1943. Anthropological Records 8(3):279.
6. SWANSON, E. 1969. (Professor and Chairman, Department of Anthropology, Idaho State University.) Personal communications.

For reprints: Philip A. May, Rural Route #1, Florence, Montana 59833

BEST COPY AVAILABLE



SUICIDE AND THE AMERICAN INDIAN

By PHILIP A. MAY, M.A., and LARRY H. DIZMANG, M.D.

In the past few years, self-destructive behavior among American Indians has received considerable concern. It is not clear whether this concern is in response to a recent rise in the incidence of self-destruction among American Indians or to the new realization of a chronic problem. Some evidence indicates that certain suicidal behavior

BEST COPY AVAILABLE

has cultural roots within some tribes;[1,2,3] however, other people, most notably many contemporary Indians, maintain that self-destruction is a relatively recent development. Whichever may be more correct, suicide, suicide attempts, and other forms of self-destruction have recently been recognized as major problems among a number of American Indian groups.

A SURVEY OF RATES

Official statistics from the Indian Health Service indicate that the age-adjusted suicide rate for American Indians and Alaska natives on reservations is 23.1 per 100,000[4]—more than twice the rate for the general United States population (11.1 in 1967). A general rate such as this, however, tells very little about the true nature of suicide and self-destructive behavior among American Indians. In some tribes, self-destructive behavior—including alcoholism, suicide, and other violent deaths—is much more prevalent than in other tribes. In addition, we have no reported evidence that suicide is a problem among Indians in urban settings.

Although official statistics on suicide are in many cases inaccurate, an examination of data from various tribes in the United States illustrates the variation that occurs from one group to another. The Navaho of the Southwest have a suicide rate (9.0 per 100,000 for 1962) similar to that for the rest of the United States. When the rates of the different Pueblo people in New Mexico are averaged, their rate of suicide is also similar to that for the rest of the nation (10.23). But examination of individual Pueblo groups shows a range of rates from 0 to 22.2.[5] Recently Shore[6] has reported that the rate of the Northwest Indian tribes also approximates the national average. The Apache of New Mexico had a rate of 20.8 for the years 1953 through 1962.[3] On the Great Plains the suicide rates of many tribes are higher than the overall United States average.[2,7,8] Finally, among several tribes that had cultures marginal to the Plains and the Great Basin areas (i.e., the Uintah-Ouray Utes and the Shoshone-Bannock), the rates are somewhat higher than the United States average.[2,7] We can conclude from these highly variant rates that each tribe has its own uniquely evolved way of life and, consequently, a wide variation in suicide rates.

Suicidal death, however, is not the only parameter of self-destruction; self-destructive behavior manifests itself in several other ways in American Indian society. The leading cause of death among Indians and Alaska natives is accidents,[4] whereas it is fourth among the general population of the United States. Death from cirrhosis of the liver, usually associated with excessive drinking, is four times more frequent among Indians and Alaska natives than among others in the United States.[4] Since the general suicide rate of American Indians is slightly higher than that of the general population, and in light of research on several reservations, we have reason to believe that the incidence of suicide attempts is high in some tribes.[7,8] Again, these rates are general, and there is a wide variation among tribes, some having high incidences of these problems and others having virtually none.

PATTERNS OF INDIAN SUICIDE

Although variation occurs from tribe to tribe, some common patterns regarding the act of suicide have emerged.

Virtually all the current statistics and studies have found Indian suicide to be a behavior of younger persons. The vast majority of all American Indians who commit suicide are between the ages of 15 and 39. Navaho suicides are generally between ages 25 and 39,[3] Sioux between ages 16 and 33,[7] and Shoshone-Bannock between 14 and 39 but usually under the age of 30.[8] Thus, suicide on many reservations occurs among the adolescents and young adults. This is in striking contrast to the general United States population, in which suicide incidence increases as age increases; the older an Anglo-American (especially a male) is, the more likely he is to commit suicide. The Indian pattern of youthful suicide is somewhat similar to the pattern shown by United States blacks, but the black rate is lower.

Virtually all the current studies have found Indian suicide to be a behavior of younger persons

The age of suicide attempters, as in the rest of the United States, is young among American

BEST COPY AVAILABLE

Indians. Also similar to the rest of the population is the fact that American Indians who attempt suicide are generally female,[7,8] while completed suicides occur predominantly among males.

A high percentage of both completed and attempted suicides occur when the individual is or has been drinking. The method of suicide varies from tribe to tribe. An overdose of medication is a common form of completed and attempted suicide on the Plains,[7] while more lethal methods, such as shooting or hanging, are common in many other areas.[7,8] The setting of a suicidal death also varies. Jails are a common place for Indian suicides and attempts in some areas, while the individual's home is the most common place of occurrence on many reservations.

POSSIBLE EXPLANATIONS

Recent sociopsychological studies of American Indian suicide express a number of common themes regarding precipitating factors. Generally they emphasize sociocultural factors rather than psychological or other phenomena. "The sociocultural determinants apply so clearly that . . . it is . . . unwarranted . . . to talk about individual dynamics or neurobiochemistry outside the context of the broad sociocultural picture."[9]

One general theme that appears in virtually all studies in this area is social disorganization. With the coming of Anglo-Americans and their dominant culture, American Indian society has been subjected to forced change. The contact with Western culture has led, in many cases, to rapid social change and a breakdown of traditional sociocultural systems. This process generally alters the degree of integration within the less dominant system. Within a rapidly changing or disorganized system, the norms, values, and roles become unclear, generally resulting in severe psychological stress for many persons.[7] Because this type of situation has occurred in many American Indian societies, many authors point to it as a predisposing factor to self-destruction.

Cultural conflict is a similar source of stress. The values of Indian and white society are often viewed as opposites, creating a great deal of friction between proponents of each culture. The dominant Anglo-American ideas are generally stressed to Indian youth in the schools, through the mass media, and in virtually all contacts off the reservation. A strong pressure, both overt and covert, is placed on the American Indian to acculturate and become "more like everyone else in America." At the same time, pressure from the traditional culture urges him to "remain an Indian." Thus, the American Indian is caught between two different existences and is somewhat marginal in each.[10] Some persons are able to live with this or resolve it in various ways, while others find it a great problem. Also, some tribes have been under more pressure to acculturate and consequently have undergone more change and unrest. Levy[9] implies that the stronger the pressure to acculturate and the more rapid the social change, the higher the incidence of self-destruction and other types of casualties will be. Added to this is the low self-esteem that is created by cultural conflict and rapid change, another factor predisposing to self-destruction.

One social institution that has been greatly altered in a number of American Indian tribes is the family. In a study of one Indian group in which rapid change and breakdown in extended and nuclear families had occurred, the researchers found a high suicide rate. When the histories of the adolescents who had committed suicide were examined and statistically compared with a control group from the same tribe, most differences pointed to an unstable and chaotic family background experienced by the suicidal youths.[9] These young people generally suffered more unpredictability and loss in their family of orientation through divorce, desertion, arrest of parents, etc.

> A strong pressure is placed on the American Indian to acculturate and become "more like everyone else in America."

Other research has dealt with the family situation of postadolescent American Indian suicides. The suicides were in many cases precipitated by domestic quarrels and other marital strife.[9,7]

Thus, the literature on Indian suicide points to rapid and forced social change as creating an atmosphere in which the psychosocial needs of individuals are not met. People are caught in a dilemma between the demands of the Indian and white societies. Many Indians in this situation find

CONTINUED

BEST COPY AVAILABLE

28

ways of coping with their difficulty; some are highly positive, some are neutral, and others contribute to the self-destructive behavior we have described.

CONCLUSION

Simple explanations or solutions for American Indian suicide and other self-destructive behavior are obviously not possible. Any attempt to deal with self-destruction among tribes with a high incidence of suicide, alcoholism, and violent death would require efforts to bolster the existing sociocultural system and especially the family. In the past, many of the traditional functions of some American Indian societies have been usurped by Western culture or taken over by the federal government. This has led to social disintegration that needs to be reversed through various means.

Emphasis need to be placed on accepting an active role in deciding or influencing the future. Government programs have made some efforts towards encouraging American Indians to be active in policy making concerning education, community programs, and some other areas, but these efforts have been quite limited and will need to be much more extensive if they are to succeed. The increased self-determination of American Indians should serve to provide gradual stimulus for restructuring societies in which this is needed. It could affect all levels of these societies and permit new roles, norms, and values to emerge.

It follows that a major task is further education, training, and encouragement of many American Indians to reassume direction of their destiny. Too often the motivated Indian has been frustrated in his efforts towards self-actualization. Whatever action is taken by American Indians in the future should be self-determined. Whether the direction taken by a particular tribe is similar to that of the white society, very traditional, or a synthesis of the two, certain skills will be necessary to carry out self-determination of any kind. Encouragement and continued assistance are vital.

In the interim, we need to actively maintain treatment for high-risk subjects. Crisis intervention and other types of counseling and therapy techniques have been used only on a limited basis on most reservations, but when mental health services are used there is some indication of success.[7,9,12] Emphasis in these programs should be not only on therapy for the clients but also on assistance and training of indigenous workers to perform mental health services on their own and determine program direction. Generally, treatment performed by indigenous tribal members in a traditional context is probably more successful[9,12] and advances the idea of self-determination.

Life in the United States during the past few years has been characterized by a great deal of change and resulting ambiguity of social meaning and values, with a corresponding rise in national statistics on suicide. Some American Indian groups are examples of this type of phenomenon, undergoing forced and rapid social change that results in symptoms of self-destruction. Meaningfulness of life and a strong social system to provide direction and minimize stress are necessary for any group of people.

BIBLIOGRAPHY

1. Barter, J.T., and Weist, R.M. *Historical and Contemporary Patterns of Northern Cheyenne Suicide.* Unpublished manuscript, 1970.

2. Dizmang, L.H. Suicide among the Cheyenne Indians. *Bulletin of Suicidology.* Washington, D.C.: U.S. Government Printing Office, July, 1967.

3. Dizmang, L.H. Observations on Suicidal Behavior Among the Shoshone-Bannock Indians. Presented at the First Annual National Conference on Suicidology. Chicago, 1968.

4. U.S. Department of Health, Education, and Welfare. *Indian Health Trends and Services: 1970 Edition.* Washington, D.C.: U.S. Government Printing Office, 1971.

5. Levy, J.E. Navajo suicide. *Human Organization 24:4* (1965), 308-318.

6. Shore, J.H. Suicide Patterns Among Major Northwest Indian Tribes. Paper presented at the American Psychiatric Association Annual Meeting, 1971.

7. May, P.A. *Suicide and Suicide Attempts on the Pine Ridge Reservation.* Mimeographed paper. U.S. Public Health Service, Community Mental Health Program, Pine Ridge, S.D., 1973.

8. Mindell, C., and Stuart, P. Suicide and self-destructive behavior in the Oglala Sioux. *Pine Ridge Research Bulletin 1* (1968), 14-23.

9. Dizmang, L.H., et al. Adolescent suicide on an Indian reservation. *Am. J. Orthopsychiatry 44:1* (1974), 43-49.

10. Resnick, H.L.P., and Dizmang, L.H. Observations on suicidal behavior among American Indians. *Am. J. Psychiatry 127:7* (1971), 58-63.

11. Byrum, J. Suicide and the American Indian: An Analysis of Recent Trends. In Bahr, H.M., Chadwick, B.A., and Day, R.C., eds. *Native Americans Today: Sociological Perspectives.* New York: Harper and Row, 1972, pp. 367-377.

12. Shore, J.H., et al. A suicide prevention center on an Indian reservation. *Am. J. Psychiatry 128:9* (1972), 76-81.

BEST COPY AVAILABLE

The Health of Native American Women by Judith A. Kitzes, MD, MPH, and Lawrence R. Berger, MD, MPH

INTRODUCTION:

This report presents much of the available data concerning reproductive health, mortality and hospital-associated morbidity for Native American women. It highlights conditions - such as alcoholism, injuries, and cervical cancer - whose prevalence and severity warrant concerted action. Issues for further study are also suggested by rates of diseases that are dramatically lower among Native American women (for example, lung cancer and heart disease).

Much of the data that appears in this report was collected by the Program Statistics Branch of the Indian Health Service (IHS). The IHS operates 48 hospitals and 84 health centers and purchases services through contractual arrangements with other medical facilities ("contract care facilities"). Population counts are based on U.S. Census Bureau enumeration. Vital event statistics are furnished to IHS by the National Center for Health Statistics (NCHS). Patient care statistics are gathered directly by IHS.

Several publications summarize Indian health statistics [1,2] and U.S. comparison data[3,4]. In addition, the IHS has compiled a number of "in-house" reports[5-7] and specific unpublished tabulations (e.g., diagnosis-specific mortality rates). Data which is cited without reference in this report are from these latter tabulations.

In fiscal year (FY) 1983, IHS had responsibilities in 28 states ("reservation states") with approximately 888,000 American Indian and Alaska Natives, 50.7 percent of them female. There is

BEST COPY AVAILABLE

a higher proportion of younger Indian women and a smaller proportion of elderly females than in the United States All Races population (Figure 1). The calculation of age-specific or age-adjusted rates is therefore important when comparing the two populations.

BEST COPY AVAILABLE

MORTALITY DATA:

Age-specific mortality rates for Native American women are higher than for U.S. women, all races, except in the age group 65 years and older (Table 1). The death rate is particularly high among women 25 -34 years old.

Table 2-6 present the major causes of death for each age category. Listed are causes which account for at least 5 deaths in the particular age group.

In 1978, there were 144 deaths of Native American women ages 15-24 (Table 2). Injuries - intentional and non-intentional - accounted for 76% of the deaths. Teenagers and young adults of all races suffer dramatically high rates of motor vehicle deaths. For Native American women in this age group, the motor vehicle injury mortality rate is 3.2 times the national average. Other non-intentional injuries occur at even higher rates compared to the U.S. as a whole. The suicide mortality rate is 2.6 times higher. Although the Native American rate is based on only 13 deaths, under-reporting is particularly likely to occur in this population because of the tremendous social stigma attached to suicide. The high rate of death from respiratory disease is based on 5 deaths, all from pneumonia.

Injuries remain the leading cause of death in the 25-34 year old age group, accounting for 48% of deaths (Table 3). The motor vehicle death rate for Native American women in this age category is 7.5 times the national average. Cirrhosis of the liver is the second leading cause of death, occurring at a rate 15 times that of the U.S. as a whole. There were almost as many deaths from

BEST COPY AVAILABLE

cirrhosis (21) as from cancer and heart disease combined (23). Homicide was the third leading cause of death. The homicide mortality rate was 4.6 times the U.S. average. Although both heart diseases and malignancy rates are lower among Native Americans overall, in this age group they are higher than nationally.

Cirrhosis is the leading cause of death among 35 to 44 year old women (Table 4). The cirrhosis mortality rate in this age category is nearly 10 times the national average. The motor vehicle death rate remains over 7 times the U.S. rate.

In the 45 to 64 year old age group, cancer and heart disease are the leading causes of death among U.S. women of all races, including Native Americans (Table 5). Markedly higher rates of cirrhosis, non-intentional injuries, and diabetes among Native Americans place these diagnoses ahead of cerebrovascular disease, the third leading cause of death among U.S. women nationally. Although kidney disease accounted for only 12 deaths (2% of the total), the mortality rate was 3.6 times the national average. Tuberculosis was the cause of 9 deaths in this age group, yielding a rate 12 times that of the U.S. all races.
The four leading causes of death are the same for elderly Native American women as for the U.S. as a whole: heart disease, cancer, cerebro-vascular disease, and respiratory illness (Table 6). The mortality rates for specific diseases, however, differ markedly. Native American women suffer higher rates of death from tuberculosis, diabetes, nutritional deficiencies, cirrhosis,

BEST COPY AVAILABLE

gallbladder diseases, non-intentional injuries, respiratory and kidney diseases. Rates are lower than nationally for neoplasms, heart and cerebrovascular diseases, and arteriosclerosis.

BEST COPY AVAILABLE

HOSPITAL DISCHARGE DIAGNOSES:

The number of patients discharged from IHS and contract care facilities with various diagnoses have been summarized for fiscal year 1979 (Table 7).[5] Discharge data from U.S. short-stay, non-Federal hospitals is also available from the National Center for Health Statistics through the National Hospital Discharge Survey[4]. The data sets are not strictly comparable, however. Because Native Americans obtain care both within and outside the IHS system, discharge figures from IHS underestimate total hospital admissions. The appropriate denominator for calculating rates of admission is ambiguous. Should all Native Americans be included, or only those utilizing IHS facilities? Should tribal enrollment or census figures be used?

One approach to this dilemma is to choose a diagnosis - such as appendicitis - that is likely to have similar rates of admission within the two populations (U.S. all races and Native American). Rates of all other discharge diagnoses can then be calculated as a function of the "appendicitis index" within each data set. The ratio of rates for each diagnosis will then reflect differential rates of admission. Of course, this approach has its pitfalls. Appendicitis admission rates may differ between the two populations because of differences in incidence or in the management of abdominal pain. Among Native Americans, certain diagnoses (such as trauma or abortions) may be more or less likely to be treated outside of IHS/contract care facilities. The approach does not take into account age-specific

BEST COPY AVAILABLE

differences in admission rates for different diagnoses (i.e., it does not age-adjust). Furthermore, the IHS data includes a large number of diagnoses in the "symptoms and ill-defined conditions" category (6.2% of all diagnoses vs. 1.6% for the NCHS data), raising concern about the reliability of rates in diagnostic categories with small numbers.

With these caveats in mind, the "appendicitis ratio" approach does provide useful insights (Table 7). Discharge rates for the following diagnoses are much higher for Native Americans in the IHS system: nephritis/nephrosis, certain causes of perinatal morbidity and mortality, infectious diseases (particularly diarrheal disease and tuberculosis), alcohol-related mental disorders, diseases of the liver, otitis media and mastoiditis, pneumonia, diseases of the parametrium and female peritoneum, and complications of pregnancy, childbirth and the puerperium. A higher rate in the last category is consistent with the increased fertility rate of Native Americans. That the ratio is 1.0 for "Accidents, poisonings and violence" probably means that the "appendicitis ratio" under-estimates admission rates in the IHS population, since mortality and other data point to a much higher rate of injuries among Native Americans. Decreased discharge rates for Natives Americans for neoplasms and heart disease are consistent with mortality data.

BEST COPY AVAILABLE

CANCER INCIDENCE AND MORTALITY:

Table 8 shows female cancer mortality rates based on IHS data for all Indian and Alaska Native deaths. It would appear from this data that the overall cancer mortality is markedly lower for Native American women compared to that of the U.S. female population as a whole. The mortality rates for neoplasms of the lung, breast, and hematopoietic system (leukemia, lymphoma) are dramatically lower. No specific cancer seems to be increased as a cause of death among Native American women compared to U.S. women of all races.

Several important concerns apply to the above conclusions. The data is not age-adjusted. The categories are overly-inclusive (e.g., "genital organs"), potentially obscuring important differences among specific cancers. The actual number of deaths in a single year among Native Americans is very small for certain cancers, making rates unreliable. This is particularly troublesome because the IHS mortality data contains a large number of deaths classified as "benign or unspecified nature".

A unique data set helps to address many of these concerns. The Surveillance, Epidemiology, and End Results (SEER) Program is an on-going project of the National Cancer Institute.[8] Begun in 1972, participating centers maintain population-based cancer reporting systems. Information is abstracted from medical records of all cancer patients seen in every hospital or other medical facility within a designated geographic area. All

BEST COPY AVAILABLE

resident death certificates which mention cancer are also abstracted. The Tumor Registry at the University of New Mexico participates in SEER. The Native American population covered includes 27% of American Indians.

Table 9 provides age-adjusted cancer mortality rates for females in the SEER system for the years 1973 through 1981. Again, the overall cancer mortality is much lower for Native American women. The rates are dramatically lower for neoplasms of the lung, breast, hematopoietic system, colon, corpus uteri, ovary and bladder. Lower rates also occur for cancers of the buccal cavity and pharynx, larynx, skin, and nervous system, although the number of deaths from which the rates are calculated are small. Cancers of the cervix uteri, kidney, and stomach occur at increased rates for Indians.

Mortality data may not reflect differences in the actual incidence of certain cancers. For example, there may be differential survival for certain cancers because of earlier diagnosis or more optimal care; or diagnoses may differ among populations with different rates of autopsy. Incidence rates of malignant cancers appear in Table 10. These data support all of the conclusions derived from the mortality data in Table 9.

BEST COPY AVAILABLE

ALCOHOL AND HEALTH:

Fetal alcohol syndrome: When women drink excessively during pregnancy, their infants may exhibit a pattern of malformations and developmental delay known as the fetal alcohol syndrome (FAS). A recent study of FAS among American Indians in the southwestern United States found the incidence to be highly variable from one cultural group to the next (Table 11). The differences seemed to correlate better with the drinking style of each group rather than with overall alcohol consumption. There was some evidence that FAS incidence was increasing, especially among the Navajo and Pueblo communities.[9]

Alcohol-related mortality: Although there are many causes of cirrhosis of the liver, the majority of cirrhosis-related deaths are alcohol-related.[10] Mortality rates for cirrhosis are highest in the 55-64 year old age group (Table 12). Rates for Native Americans are 2.3 times the national average in the 65-74 year age group, 15 times as high among 25-34 year olds. Cirrhosis accounts for one out of five deaths of Native American women ages 35-44. That the mortality rate is already more than ten times the national average among 15-24 year olds suggests that serious drinking begins early for many Native American women.

Another measure of alcohol-related mortality is based on numbers of death certificates with cause-of-death noted as "alcoholism", "alcoholic psychoses", and "cirrhosis of the liver with mention of alcohol." Dramatically increased rates of alcohol-related deaths for Native Americans are again evident

BEST COPY AVAILABLE

(Table 13). Among Indian adolescents and young adults, the alcoholism death rate for females is 25 to 30 times the national average.

Comparisons with Native American males: Whereas the ratio of male to female cirrhosis mortality rates is about two-to-one for the U.S. as a whole,[10] it is nearly one-to-one among Native Americans (Table 14). Male mortality from alcohol-related diseases overall is almost double that of females, and the alcohol-related hospital discharge rate is nearly four times as high for males.

An alcohol-related discharge has at least one of the following diseases reported on the hospital discharge form: alcoholic psychosis, alcoholism, cirrhosis of the liver (alcoholic), acute or chronic pancreatitis, or toxic effect of ethyl alcohol.[6] There are many possible reasons why males would have an alcohol-related hospital discharge rate disproportionately greater than their mortality rates. Alcohol-related morbidity might be lower among females because of physiologic factors or differences in drinking patterns. Admission rates might differ because alcohol-related problems are more likely to be diagnosed in males or because treatment programs (e.g., in-hospital detoxification programs) are more available for males. Finally, physicians may be less apt to list alcoholism as a supplemental diagnosis on the discharge form of a female patient because of the increased social stigma.

BEST COPY AVAILABLE

REPRODUCTIVE HEALTH:

Fertility rates and family planning: In every age group, but particularly at each end of the reproductive age spectrum, Native Americans have higher rates of deliveries per population than the national average (Table 15).

Data on family planning practices are very scarce. A national survey in 1976 found that 68% of U.S. married women of reproductive age used some method of contraception[11] No comparable survey has been performed among married Indian and Alaska Native women. However, only 22% of Native American women of reproductive age (15-44 years) received family planning services through IHS facilities in 1979[7]. Oral contraception was the most common method, but the intra-uterine device was also popular (Table 16).[7,12]

Maternal mortality and pregnancy outcomes: Since 1958, when the maternal death rate for Indians and Alaska Natives was more than twice the national average, maternal deaths have become vanishingly rare (Figure 2). For the period 1978-1980, the maternal death rate for Native Americans in reservation states was 11.4 per 100,000 live births. The rate for U.S. All Races was 9.6 and for U.S. "other than white", 22.7.[2]

Compared to U.S. data, the overall proportion of infants weighing less than 2,500 grams at birth is lower for Native American mothers (6.3% vs. 6.8%). Teenage Indian mothers have a notably low rate of low-birthweight infants (Table 17). In view of this, it is not surprising that the neonatal mortality rate for Native Americans also compares favorably to the U.S. rate (5.5 neonatal deaths per 1,000 births vs. 8.0 nationally).[1]

BEST COPY AVAILABLE

Cesarean section rates: For the U.S. as a whole, the Cesarean section rate in 1983 was 20.3%.[13] Of the total, 65.2% were primary sections. The Cesarean section rate in IHS hospitals staffed by Ob/Gyn specialists (73% of all IHS deliveries) was 17.4%, with 51.7% representing primary sections.

Operations and non-surgical procedures: Obstetrical procedures accounted for 31% of all operations and non-surgical procedures performed in IHS hospitals and contract care facilities in 1979. Gynecologic procedures were an additional 10%.[5] For U.S. short-stay, non-Federal hospitals the figures are 12% and 14%, respectively.[4]

Since 1980, the Indian Health Service has been prohibited by Federal policy from paying for or performing elective abortions. An estimate of the extent to which Indian women are receiving legal abortions outside of the IHS system can be made from state vital statistics. Data from New Mexico (Table 18) demonstrates that Native Americans have the lowest ratio of abortions to live births (73 per 1,000) of any ethnic group.[14] Both socio-cultural issues and barriers to access to abortion services undoubtedly play a role.

In IHS hospitals staffed by Ob/Gyn specialists in 1983, there were 109 sterilization procedures per 1,000 deliveries. The ratio in non-Federal short-stay hospitals in the U.S. (1981) was 200 per 1,000 deliveries.

BEST COPY AVAILABLE

SUMMARY AND CONCLUSIONS:

Dramatic improvements in the health of Native American women have occurred through environmental interventions to control infectious diseases and the provision of quality medical services.[1,2] Nevertheless, mortality rates remain much higher for Indian women compared to the general population of women in the U.S. Injuries, both non-intentional and intentional, are a major killer, accounting for three-fourths of all deaths in the 15-24 year old age group. Among Indian women 25 to 34 years of age, motor vehicle deaths occur at a rate eight times the national average. Alcohol is clearly a contributing factor to the high injury rates. Cirrhosis mortality rates for Indian women are already ten times the national average in the 15-24 year old age group. Obviously, some Indian women are drinking alcohol starting at a young age and drinking it heavily. Programs for the identification and treatment of Indian women with alcohol problems are rare.[15]

With a few exceptions, cancers occur at much lower rates among Native American women. Lung cancer incidence and mortality is particularly low, almost certainly a reflection of lower rates of cigarette smoking.[16] Designing approaches to maintain the low prevalence of smoking among Indian youth is a unique public health challenge. The high rate of cervical cancer in Indian women suggests another important community health priority: intensive cytologic screening. Evaluation of a cytologic detection program for Indian women in the Southwest found that the age groups with the highest proportion screened had the lowest rates of invasive cervical carcinoma.[17]

BEST COPY AVAILABLE

Cancer of the kidney also occurs at a higher rate among Indian women than nationally. Although the actual number of deaths and hospital admissions were small, both mortality rates and hospital discharge rates were clearly increased for kidney diseases ("nephritis/nephrosis"). Both clinical and epidemiologic studies are needed to define the nature and risk factors for kidney-related mortality and morbidity in this population.

Diabetes is a major cause of mortality among Indian women 45 years of age and older. Mortality rates for diabetes in this age group are two to four times the national average. Diet, obesity, alcohol consumption, and genetics may be contributing factors.

Data on reproductive health depict one of the great success stories of Indian health programs. Maternal mortality, neonatal mortality, and low-birthweight rates in the Native American population are at or below the rates for U.S. all races. The high fertility rate and low rates of contraceptive use, elective abortion, and sterilization procedures in the Indian population are as much socio-cultural issues as medical ones.

BEST COPY AVAILABLE

REFERENCES

1. Indian Health Service Chart Series, Fiscal Year 1986. Program Statistics Branch, IHS, Rockville, February 1985.

2. Indian Health Service Chart Book Series, June 1984. Indian Health Service, Program Statistics Branch.

3. Health, United States 1983. DHHS Publication No. (PHS) 84-1232. National Center for Health Statistics, Bethesda, 1984.

4. Detailed Diagnoses and Surgical Procedures for Patients Discharged from Short Stay Hospitals, United States 1979. DHHS Publication No. (PHS) 82-1274-1, NCHS, Hyattsville, January 1982.

5. Discharge Summary Fiscal Year 1979 Indian Health Service and Contract General Hospitals. Office of Program Statistics, Indian Health Service.

6. Alcohol-related discharges from Indian Health Service and contract general hospitals, fiscal year 1979. Office of Program Statistics, IHS, November 1980.

7. Family Planning Program Fiscal Year 1979. Indian Health Service Administration.

8. Horm JW, Asire AJ, Young JL, Pollack ES (editors): SEER Program: Cancer Incidence and Mortality in the United States 1973-1981. NIH Publication No. 85-1837, National Cancer Institute, Bethesda, Revised November 1984.

9. May PA, Hymbaugh KJ, Aase JM, Samet J: Epidemiology of fetal alcohol syndrome among American Indians of the Southwest. Social Biology 1983;30:374-387.

10. Johnson S: Cirrhosis mortality among American Indian women: Rates and ratios, 1975 and 1976. In Galanter M: Currents in Alcoholism, Volume VII, Grune and Stratton, 1980, pages 455-463.

11. Mosher WD: Contraceptive utilization, United States 1976. Vital and Health Statistics, Series 23: Data from the National Survey of Family Growth, Number 7, March 1981, pages 1-58.

12. Current Functioning and Future Priorities in Family Planning Services Delivery. Alan Guttmacher Institute, December, 1983.

13. Taffel SM, Placek PJ, Moien M: One-fifth of 1983 U.S. births by Cesarean section. Am J Public Health 1985; 75:190.

14. Abeyta M: New Mexico Residents Reported Legal Induced Abortions, 1983. Health Statistics Section, Health and Environment Division, Santa Fe, New Mexico, November, 1984.

BEST COPY AVAILABLE

15. Asse JH: The fetal alcohol syndrome in American Indians: A high risk group. Neurobehavoral Toxicology and Teratology 1981;3:153-156.

16. Samet JM, Key CR, Kutvirt DM, et al: Respiratory disease mortality in New Mexico's American Indians and Hispanics. Am J Public Health 1980;70:492-497.

17. Jordan SW and Key CR: Carcinoma of the cervix in Southwestern American Indians: Results of a cytologic detection program. Cancer 1981;47:2523-2532.

BEST COPY AVAILABLE

FIGURES AND TABLES

Figure 1	Female population distribution.
Figure 2	Maternal mortality rates.
Table 1	Female mortality rates.
Table 2	Mortality rates: females 15 to 24 years.
Table 3	Mortality rates: females 25 to 34 years.
Table 4	Mortality rates: females 35 to 44 years.
Table 5	Mortality rates: females 45 to 64 years.
Table 6	Mortality rates: females 65 and older.
Table 7	Hospital discharge rates.
Table 8	Female cancer mortality rates.
Table 9	Age-adjusted female cancer mortality rates.
Table 10	Age-adjusted female cancer incidence rates.
Table 11	Incidence of fetal alcohol syndrome.
Table 12	Female cirrhosis mortality.
Table 13	Alcohol-related female mortality.
Table 14	Sex-specific alcohol statistics.
Table 15	Fertility rates by age group.
Table 16	Family planning services by method.
Table 17	Pregnancy outcomes.
Table 18	Legal abortions, New Mexico.

BEST COPY AVAILABLE

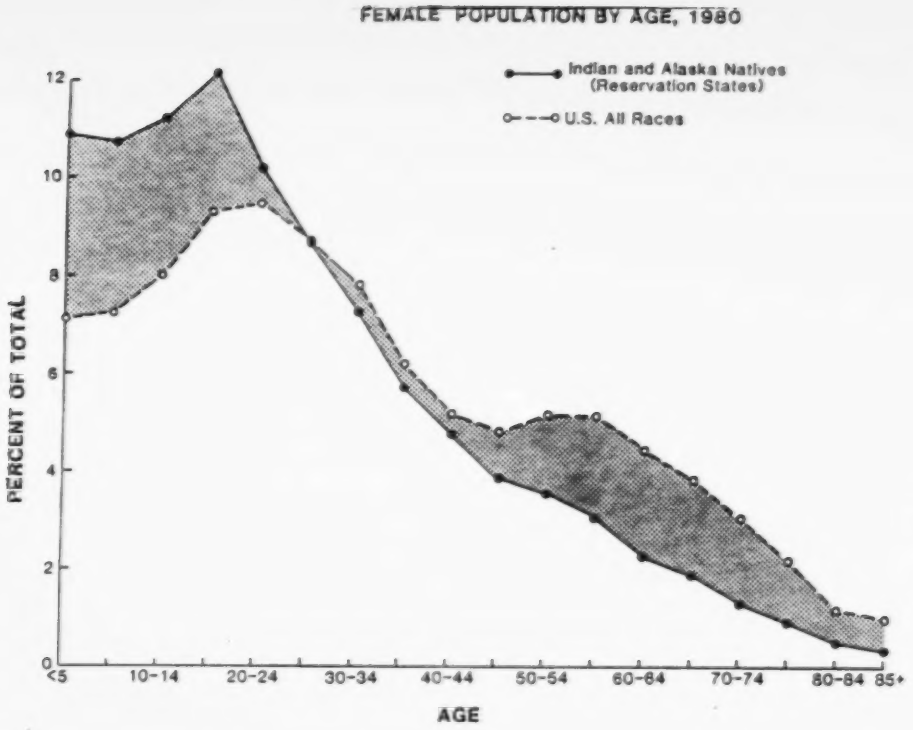

FEMALE POPULATION BY AGE, 1980
Indian and Alaska Natives (Reservation States)
U.S. All Races
PERCENT OF TOTAL
12
10
8
6
4
2
0
<5
10-14
20-24
30-34
40-44
50-54
60-64
70-74
80-84
85+
AGE

FIGURE 1

237

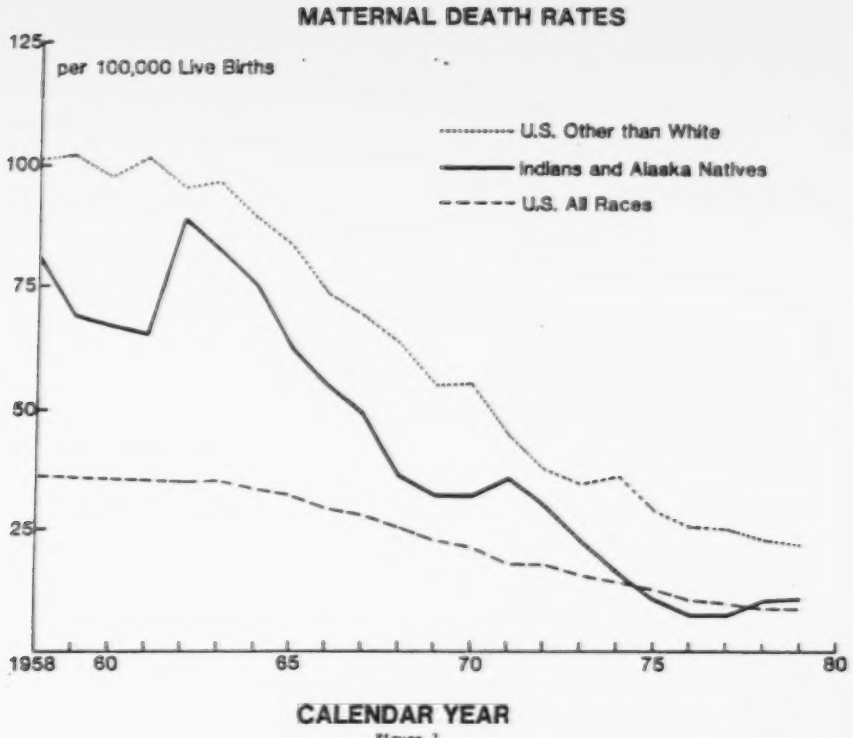


Figure 2

BEST COPY AVAILABLE

TABLE 1

FEMALE MORTALITY RATES[1]

Age Group	Native Americans[2]	U.S.[3]	Ratio
15 - 24 years	166.1	60.9	2.7
25 - 34 years	292.4	79.7	3.7
35 - 44 years	436.1	167.8	2.6
45 - 54 years	702.8	433.2	1.6
55 - 64 years	1,166.0	976.3	1.2
65 years and over	3,739.9	3,841.2	1.0

[1] Number of deaths per 100,000 female population.

[2] American Indian and Alaska Natives, reservation states, 1977-1979.

[3] U.S. all races, female population, 1978.

Source: Vital Events Branch, IHS, 4/82.

BEST COPY AVAILABLE

TABLE 2

MORTALITY RATES[1]
FEMALES 15 TO 24 YEARS OF AGE

	Indian[2]	U.S.[3]	RATIO
ACCIDENTS	96.0	27.1	3.5
Motor vehicle	67.9	21.1	3.2
All other	28.0	6.0	4.7
SUICIDE	14.0	5.3	2.6
HOMICIDE	7.5	5.9	1.3
RESPIRATORY	5.4	1.2	4.5

[1] Rate per 100,000 population.

[2] American Indian and Alaska Native, reservation states, 1978.

[3] U.S. all races, 1977.

BEST COPY AVAILABLE

TABLE 3

MORTALITY RATES[1]
FEMALES 25 TO 34 YEARS OF AGE

	Indian[2]	U.S.[3]	RATIO
ACCIDENTS	99.5	16.9	5.9
Motor vehicle	82.4	11.0	7.5
All other	17.2	5.9	2.9
CIRRHOSIS	36.0	2.4	15.0
HOMICIDE	29.2	6.4	4.6
MALIGNANCY	22.3	14.7	1.5
HEART DISEASE	17.2	5.1	3.4
RESPIRATORY	8.6	1.9	4.5

[1] Rate per 100,000 population.

[2] American Indian and Alaska Native, reservation states, 1978.

[3] U.S. all races, 1977.

BEST COPY AVAILABLE

TABLE 4

MORTALITY RATES[1]
FEMALES 35 TO 44 YEARS OF AGE

	Indian[2]	U.S.[3]	RATIO
CIRRHOSIS	100.2	10.2	9.8
ACCIDENTS	100.2	17.4	5.8
Motor vehicle	69.7	9.6	7.3
All other	30.5	7.8	3.9
HEART DISEASE	45.7	23.1	2.0
MALIGNANCY	37.0	55.1	0.7
HOMICIDE	13.1	5.7	2.3
CEREBROVASCULAR	10.9	10.1	1.1

[1] Rate per 100,000 population.

[2] American Indian and Alaska Native, reservation states, 1978.

[3] U.S. all races, 1977.

BEST COPY AVAILABLE

TABLE 5

MORTALITY RATES[1]
FEMALES 45 TO 64 YEARS OF AGE

	Indian[2]	U.S.[3]	RATIO
HEART DISEASE	179.2	185.9	1.0
MALIGNANCY	177.6	272.8	0.7
CIRRHOSIS	161.6	25.2	6.4
ACCIDENTS	86.4	24.1	3.6
Motor vehicle	43.2	10.4	4.2
All other	43.2	13.7	3.2
DIABETES	65.6	17.8	3.7
CEREBROVASCULAR	44.8	47.4	0.9
RESPIRATORY	36.8	18.5	2.0
KIDNEY	19.2	5.3	3.6
TUBERCULOSIS	14.4	1.2	12.0

[1] Rate per 100,000 population.

[2] American Indian and Alaska Native, reservation states, 1978.

[3] U.S. all races, 1977.

BEST COPY AVAILABLE

TABLE 6

MORTALITY RATES[1]
FEMALES 65 YEARS OF AGE AND OLDER

	Indian[2]	U.S.[3]	RATIO
HEART DISEASE	1,205.0	1,976.2	0.6
MALIGNANCY	604.5	750.7	0.8
CEREBROVASCULAR	417.3	656.0	0.6
RESPIRATORY	292.5	168.6	1.7
DIABETES	253.5	106.0	2.4
ACCIDENTS	136.5	82.5	1.7
Motor vehicle	27.3	16.3	1.7
All other	109.2	66.2	1.6
ARTERIOSCLEROSIS	70.2	116.4	0.6
KIDNEY	58.5	33.1	1.8
CIRRHOSIS	50.7	23.4	2.2
TUBERCULOSIS	42.9	4.1	10.5
OTHER DISEASES OF ARTERIES/CAPILLARIES	39.0	62.2	0.6
SEPTICEMIA	33.1	15.0	2.3
NUTRITIONAL DEFICIENCIES	31.2	9.3	3.4
GALLBLADDER	23.4	9.9	2.4

[1] Rate per 100,000 population.

[2] American Indian and Alaska Native, reservation states, 1978.

[3] U.S. all races, 1977.

BEST COPY AVAILABLE

TABLE 7

HOSPITAL DISCHARGES - FEMALES, ALL AGES
INS AND CONTRACT HOSPITALS

Diagnosis	Number	Ratio To U.S.[1]
TOTAL (excluding newborn)	62,302	
INFECTIVE AND PARASITIC	2,617	2.3
Diarrheal	1,641	6.2
TB	169	4.0
NEOPLASMS	1,479	0.3
ENDOCRINE, NUTRITIONAL, METABOLIC	1,833	0.8
DISEASES OF THE BLOOD	263	0.4
MENTAL DISORDERS	2,179	0.7
Alcohol related	1,054	2.9
DISEASES OF THE NERVOUS AND SENSORY SYSTEMS	2,287	0.7
Otitis media, mastoiditis	928	1.7
HEART DISEASE	1,559	0.3
CEREBROVASCULAR DISEASE	288	0.2
DISEASES OF THE RESPIRATORY SYSTEM	4,487	0.8
Pneumonia	1,961	1.6
DISEASES OF THE DIGESTIVE SYSTEM	4,142	0.5
Diseases of liver	445	1.7
Diseases of gallbladder and pancreas	1,598	0.9
DISEASES OF THE GENITOURINARY SYSTEM	3,737	0.4
Nephritis and nephrosis	251	6.0
Diseases of breast	158	0.2
Diseases of ovary and fallopian tubes	163	0.2
Diseases of parametrium/female peritoneum	489	1.6
Diseases of female genital organs	1,319	0.4
COMPLICATIONS OF PREGNANCY/CHILDBIRTH/PUERPERIUM	20,352	1.6
DISEASES OF SKIN AND SUBCUTANEOUS TISSUES	1,259	1.1
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISEASES	1,077	0.3
CONGENITAL ANOMALIES	342	0.6
CERTAIN CAUSES OF PERINATAL MORBIDITY/MORTALITY	505	4.0
SYMPTOMS AND ILL-DEFINED CONDITIONS	3,858	3.1
ACCIDENTS, POISONINGS, AND VIOLENCE	5,298	1.0

[1] See text for explanation.

BEST COPY AVAILABLE

TABLE 8

FEMALE CANCER MORTALITY RATES[1]

	INDIAN[2]	U.S.[3]	RATIO
ALL NEOPLASMS	65.7	160.9	0.4
Oral	1.5	2.3	0.7
Digestive organs and peritoneum	18.5	43.7	0.4
Respiratory	6.2	20.7	0.3
Breast	8.5	31.0	0.3
Genital organs	9.1	20.3	0.5
Urinary organs	2.1	5.3	0.4
Leukemia, lymphatic, other hematopoietic	5.3	15.0	0.4
Benign neoplasms and other unspecified	14.5	2.3	6.3

[1] Rates per 100,000 population. Source: IHS Vital Statistics.

[2] For reservation states, 1978.

[3] All races, 1977.

BEST COPY AVAILABLE

TABLE 9

AGE-ADJUSTED (1970 U.S. STANDARD)
CANCER MORTALITY RATES
PER 100,000 FEMALES BY SITE, 1973-1981

SITE	AMERICAN INDIANS (N.M.)	ALL SEER AREAS[1]	RATIO
All sites	88.4	133.9	0.7
Buccal cavity and pharynx	0.0	2.0	0
Stomach	6.1	4.6	1.3
Colon	2.9	16.2	0.2
Rectum	1.3	3.0	0.4
Pancreas	8.1	7.2	1.1
Larynx	0.0	0.4	0
Lung and bronchus	1.4	17.8	0.1
Melanoma of skin	0.0	1.3	0
Breast	9.3	27.2	0.3
Cervix uteri	8.0	3.6	2.2
Corpus uteri	0.8	2.0	0.4
Ovary	3.0	8.4	0.4
Urinary bladder	0.5	2.1	0.2
Kidney and renal pelvis	4.0	1.8	2.2
Brain and CNS	0.2	3.1	0.1
Hodgkin's disease	0.0	0.7	0
Non-Hodgkin's lymphoma	1.7	4.2	0.4
Leukemias	2.4	5.0	0.5

[1] See text for explanation.

BEST COPY AVAILABLE

TABLE 10

AGE-ADJUSTED INCIDENCE RATES
(1970 U.S. STANDARD)
OF MALIGNANT CANCERS
PER 100,000 FEMALES BY SITE, 1973-1981

SITE	AMERICAN INDIANS (N.M.)	ALL SEER AREAS[1]	RATIO
All sites	165.1	302.8	0.6
Buccal cavity and pharynx	0.9	6.4	0.1
Stomach	11.7	6.1	1.9
Colon	8.2	31.4	0.3
Rectum	3.6	11.7	0.3
Pancreas	8.9	7.7	1.2
Larynx	0.0	1.4	0
Lung and bronchus	3.3	24.6	0.1
Melanoma of skin	0.0	6.7	0
Breast	23.3	85.3	0.3
Cervix uteri	21.0	11.2	1.9
Corpus uteri	3.1	27.1	0.1
Ovary	7.2	13.5	0.5
Urinary bladder	0.0	6.8	0
Kidney and renal pelvis	6.2	4.4	1.4
Brain and CNS	0.7	4.5	0.2
Hodgkin's disease	0.2	2.3	0.1
Non-Hodgkin's lymphoma	5.0	8.3	0.6
Leukemias	4.0	7.8	0.5

[1] See text for explanation.

BEST COPY AVAILABLE

TABLE 11

ESTIMATED INCIDENCE OF FETAL ALCOHOL SYNDROME

Population	Affected infants per 1,000 births
NAVAJO	1.4
PUEBLO	2.0
SOUTHWESTERN PLAINS	9.8
Seattle	1.3
France	1.4
Sweden	1.7

Source: Reference 9.

BEST COPY AVAILABLE

TABLE 12

FEMALE CIRRHOSIS MORTALITY[1]

Age group	Indiana[2]	U.S.[3]	Ratio
All ages	35.3	9.6	3.7
15-24 years	3.2	0.3	10.7
25-34 years	36.0	2.4	15.0
35-44 years	100.2	10.2	9.8
45-54 years	133.1	22.1	6.0
55-64 years	200.5	28.2	7.1
65-74 years	61.1	27.1	2.3

[1] Deaths per 100,000 population.

[2] American Indian and Alaska Natives, reservation states, 1978.

[3] U.S., all races, 1977.

61-183 0 - 86 - 9

BEST COPY AVAILABLE

TABLE 13

ALCOHOL-RELATED FEMALE MORTALITY RATES[1]

Age group	Indians[2]	U.S.[3]	Ratio
All ages	34.2	4.6	7.4
15-24 years	5.4	0.2	27.0
25-34 years	51.5	1.7	30.3
35-44 years	111.0	6.8	16.3
45-54 years	122.0	13.2	9.2
55-64 years	94.6	13.9	6.8
65-74 years	36.7	9.1	4.0

1 Deaths per 100,000 population with cause of death listed as alcoholism, alcoholic psychoses, or cirrhosis with alcohol.

2 American Indian and Alaska Natives, reservation states, 1978.

3 U.S., all races, 1977.

BEST COPY AVAILABLE

TABLE 14

SEX-SPECIFIC ALCOHOL STATISTICS FOR
NATIVE AMERICANS

	Male	Female	Male/Female
Cirrhosis mortality, 1976	59.75	49.84	1.2
Alcoholism mortality, 1978 - 1980	49.2	27.9	1.8
Alcohol-related IHS discharges, 1979	14,424	3,912	3.7

BEST COPY AVAILABLE

TABLE 15

FERTILITY RATES
BY AGE GROUP, 1980

Age Group	Y.M.S.	U.S.	RATIO
15-19	103.4	53.4	1.9
20-24	180.6	115.1	1.6
25-29	134.4	112.9	1.2
30-34	73.4	61.9	1.2
35-39	32.5	19.8	1.6
40-44	9.7	3.9	2.5

BEST COPY AVAILABLE

TABLE 16

WOMEN RECEIVING FAMILY PLANNING SERVICES
BY METHOD OF CONTRACEPTION

Method	I.N.S. 1969	I.N.S. 1979	U.S. 1981
Oral	76	64	65
IUD	22	27	6
Other	3	10	29

Source: References 7 and 12.

BEST COPY AVAILABLE

TABLE 17

PREGNANCY OUTCOMES

	INDIANS[1]	U.S.[2]
Percent low birthweight[3]		
All live births	6.3	6.6
Age of mother under 20:	6.8	9.5
20 - 24:	5.9	6.9
25 - 29:	6.0	5.8
30 - 34:	6.5	5.8
35 and older:	8.0	7.3
Neonatal mortality rate[4]	5.5	8.0

1 Indians and Alaska Natives, 1980-1982.

2 U.S. all races, 1981.

3 Infants weighing under 2,500 grams.

4 Infants dying in the first 27 days of life per 1,000 live births.

BEST COPY AVAILABLE

TABLE 18

REPORTED LEGAL INDUCED ABORTIONS
NEW MEXICO RESIDENTS, 1983

	BIRTHS	ABORTIONS	RATIO[1]
U.S., 1980			359.0
NEW MEXICO TOTAL	27,508	5,010	182.1
Hispanic	12,320	1,802	146.3
Non-Hispanic white	10,522	2,774	263.6
INDIAN	3,615	262	72.5
Black	707	122	172.6
Other	344	42	122.1

[1] Number of abortions per 1,000 live births.

Source: New Mexico Vital Statistics, 1983.

BEST COPY AVAILABLE

Childhood Injuries in a Native American Community

by Kitzes, Judith, A., M.D., M.P.H., Albuquerque Area Indian Health Service and Berger, Lawrence R., M.D.

Introduction:

Injuries have become the leading cause of death and disability in childhood in this country. Native American populations have higher rates of injury than the rest of the nation. In one Indian community in the Albuquerque Area, its injuries are the leading cause of death and hospitalization, and are second only to respiratory complaints as the leading reason for outpatient visits. The injury rate of children requiring hospitalization in this community of the Indian Health Service is three times that of the Albuquerque Area IHS (AAIHS) as a whole.

This report is intended to answer several questions concerning pediatric injuries in the study community :

- What are the most common causes of injury?
- What are the causes for the more severe injuries?
- What accounts for the dramatically higher rates of injury?
- What approaches might reduce the injury rate?

In order to answer the above questions data was obtained and analyzed from the following sources:

1. Mortality Data: Indian Health Service
   Vital Statistics
   New Mexico Office of Vital Statistics
   New Mexico Office of the Medical Examiner
2. Hospital Discharge Data:
   New Mexico Foundation for Medical Care
   IHS Inpatient Data Report No. 17
3. Medical Records Review
4. Ambulatory Patient Care Data: IHS Report No. 15
5. IHS - Mental Health Statistics Report
6. Population Demographics: 1. BIA - Office of Financial Management
   2. Albuquerque Area - Planning/Evaluation Branch

SUMMARY:

1. Children in the study community under 16 years of age have three times the rate of hospitalization for injuries as AAIHS as a whole. (Table 1)
2. Intentional injuries have increased at a more rapid rate than injuries in general during the past decade. (Table 2)

BEST COPY AVAILABLE

3. The major causes of injury resulting in hospitalization are falls (24%), intentional injuries - child abuse, assaults, and suicide attempts - 22%, and motor vehicles (21%). (Table 3)

4. Motor vehicles are far and away the major cause of injury-related deaths in children. (Table 4)

5. The distribution of childhood injuries by age and type of injury is very similar for the study community and AAIHS as a whole. The dramatically higher rates of injury in the study community therefore cannot be explained by an excess of one type of injury or a particularly vulnerable age group. (Table 5 & 6)

6. The socio-economic conditions in the study community are not worse than those of the AAIHS communities as a whole. (Table 7)

7. Prevalence of family stress, especially alcohol abuse, is much higher in this study community than in other Indian communities. (Table 8 & 9)

8. Medical records of injured children often fail to note the circumstances of injury, the child's current family situation, or the need for social service evaluation. Children at high risk of additional injuries are therefore likely to remain unidentified.

RECOMMENDATIONS:

A. Reducing the overall incidence of injuries to children:

1. Although there are several specific types of injuries and injury risk factors that can be targeted for action, a more global approach is required if the overall rate of injuries is to be sharply reduced. A Community Task Force on Family Health could be established to review medical, social, educational, and legal approaches to improving family function. Among the issues for the Task Force to consider would be the early identification and treatment of alcohol problems; improving collaboration between IHS, BIA, and Tribal agencies involved in family welfare; and strengthening existing programs for families, such as counselling services.

2. Insight into possible injury reduction strategies requires adequate data. Medical record-keeping for children with injuries is excellent overall, but could be improved by:

   a. including more details about the circumstances of injury;

   b. noting who brought the child to the hospital, and who is the primary caretaker;

   c. indicating if a referral was made for a home visit or social evaluation;

   d. including "recurrent injuries" as a diagnosis on the patient's problem list.

BEST COPY AVAILABLE

B. Motor vehicle injuries:

The obvious priorities for prevention are:

1. providing occupant restraints (car seats, seat belts, air cushions) to protect individuals of all ages;

2. reducing drunk driving by teenagers and young adults.

C. Teenagers as a high-risk group:

1. School-based health and counselling programs for Indian youths.

2. Teenagers who are arrested, become runaways, or are truant at school deserve referral for an in-depth social evaluation.

3. There is a need for organized recreational activities for teenagers during the school year, and especially during summers.

4. Adolescents seen for serious injuries (especially motor vehicle and inflicted injuries) warrant a blood alcohol determination as part of their treatment. Those with elevated BACs should be referred for alcohol counseling.

5. A driver under the age of 18 determined to be legally intoxicated should have revocation of license until age 18 in addition to any other penalties required by law.

D. Suspected child abuse and neglect:

1. Prevention:

a. A home visitor program for every family in prenatal care would provide both parent support and early identification of family problems. Visits would continue after delivery, at least once each year for the first 4 years, and more frequently depending on need.

b. Other approaches to the prevention of child abuse and neglect - respite day care, telephone hotlines, parenting classes, etc. - needs to be reviewed by the Community Task Force suggested above.

2. Identification:

a. An in-service for IHS staff on identification and management of SCAN should be conducted on a yearly basis.

b. Since children over the age of 5 are only seen on an ad-hoc basis, IHS should include health maintenance visits for children 6 to 18 at least once every 2-3 years. Age-appropriate concerns, a physical exam, and a social history would be part of each visit.

c. A social history form should be part of each chart, as a separate section for easy access (as is the case for lab reports, consults, etc.)

BEST COPY AVAILABLE

d. Children who are treated for injuries on 3 or more occasions, or who suffer any serious injury, deserve a referral for a home visit for an environmental and social assessment. Field health nurses and community health representatives can be trained for this purpose.

e. Periodic chart reviews should be performed to identify children with multiple injuries and other indications of possible psychological stress (frequent missed appointments, psychosomatic complaints, runaways).

3. Management:

a. The Child Protection Team (CPT) should consider instituting formal treatment plans for each referred SCAN family. This would include assigning a case manager to each family who would be accountable for effecting and monitoring the treatment plan. Other ways to facilitate the team's work include adoption of a uniform protocol for investigation and follow-up, and establishment of a system of patient tracking, which could be computerized as in the Santa Fe Service Unit.

b. Representatives from law enforcement and the courts should be included on the CPT.

BEST COPY AVAILABLE

TABLE 1

AAIHS HOSPITAL DISCHARGE DATA*

FOR INJURIES TO CHILDREN (BIRTH - 15 YEARS)

1981 - 1982

COMMUNITY	NUMBER OF UNIQUE PATIENTS FOR '81 & '82	1981 POPULATION 0 - 15 YRS.	ANNUALIZED INJURY RATE**
STUDY COMMUNITY	43	806	26.7
A	8	237	16.9
B	5	251	10.0
C	8	358	11.2
D	3	218	6.9
E	33	1,400	11.8
F	32	2,563	6.2
G	18	995	9.0
H	15	928	8.1
I	22	791	13.9
ALL AAIHS	262	14,766	8.9

*From NM Foundation for Medical Care.

**Calculated as column 2 - (2 x column 3) x 1,000 = rate per 1,000 children.

BEST COPY AVAILABLE

TABLE 2

RATES[1] OF OUTPATIENT VISITS FOR INJURIES

FOR STUDY COMMUNITY AND AAIHS, ALL AGES, 1974 AND 1980

	STUDY COMMUNITY		AAIHS	
	Unintentional	Other[2]	Unintentional	Other
1974	283	121	152	56
1980	350	257	163	86
% INCREASE	24%	112%	7%	54%

[1] Number of injuries per 1,000 population.

[2] "Other" category includes suicide, purposefully infliced, and child abuse, as well as "undetermined, invalid, and other".

Source: 1981 AAIHS Safety Program Section: Albuquerque Area Indian Accident Profile Statistical Data.

AAIHS: 1976 - 1980 Health Indicators.

61-183 0 - 86 - 10

BEST COPY AVAILABLE

TABLE 3

AAIHS INPATIENT ADMISSIONS FOR PEDIATRIC
INJURIES AND POISONINGS
DISTRIBUTION BY CAUSE OF INJURY

Cause of Injury	Percent of Admissions	
	Study Community[1]	All AAIHS[2]
Motor vehicle injuries	21	24
All other transport injuries		7
Non-intentional poisonings	12	6
Falls	24	20
Fire, flames, or unspecified burns		2
Hunger, thirst, exposure, neglect		1
Injuries due to animals/plants	2	3
Submersion, suffocation, foreign bodies through an orifice	2	2
Struck/crushed by another person or object	5	10
Machinery		2
Cutting/piercing object	2	3
Firearms[3]	2	1
Explosion, hot or caustic substance/ object and electric current		2
Suicide and self-inflicted injury	7	5
Assault, child abuse	17	8
Cause unknown	5	3
	(N = 42)	(N = 147)

[1]1981 and 1982, first admissions only. Source: medical record review by Dr. L. Berger

[2]1982 only. Source: NM Foundation for Medical Care.

[3]Includes all firearms injuries that did not specifically state "assault".

BEST COPY AVAILABLE

TABLE 4

Injury Deaths of Study Community Residents,

Age under 20 years (1977 - 1984)

Age	Sex	Circumstance of Death	Comments
2 yrs.	F	Passenger in automobile	Single-vehicle collision
2 yrs.	F	Child abuse	Caretaker had been drinking
9 mos.	F	Passenger in collision	Unrestrained, thrown out of window
9 yrs.	M	Passenger in collision	Head-on
18 yrs.	M	Driver in collision	BAC = .20
18 yrs.	M	Driver in collision	BAC not detectable
19 yrs.	M	Driver in collision	BAC = .37
under 1 yr.	F	Aspirated object	

Source: New Mexico Office of the Medical Investigator.
New Mexico Office of Vital Statistics.

BEST COPY AVAILABLE

TABLE 5

OUTPATIENT VISITS FOR SPECIFIC TYPES OF INJURY:

ALL AGES, 1980

	Study Community No. (%)	AAIHS No. (%)	National IHS No. (%)
Falls	477 (35)	3,139 (27)	40,911 (26)
Cutting-Piercing	78 (6)	896 (8)	11,736 (7)
Motor vehicle	59 (4)	555 (5)	8,861 (6)
TOTAL	1,349 (100)	11,601 (100)	157,832 (100)

Source: 1981 Albuquerque Area Indian Accident Profile.
IHS-APC (NAISC).

BEST COPY AVAILABLE

TABLE 6

AAIHS INPATIENT ADMISSIONS FOR

PEDIATRIC INJURIES AND POISONINGS, 1981 AND 1982:

DISTRIBUTION BY AGE GROUP

AGE GROUP	(N = 46) HIGH ADMISSION GROUP	(N = 216) OTHER TRIBES
Less than 1 year	4.3%	6.5%
1 - 5 years	34.8%	35.2%
6 - 10 years	19.9%	21.7%
11 - 14 years	38.4%	39.1%

Source: NM Foundation for Medical Care, 07/08/83.

BEST COPY AVAILABLE

TABLE 7

ESTIMATES OF RESIDENT INDIAN POPULATION AND

LABOR FORCE STATUS, JANUARY, 1985*

	BIA TOTAL ESTIMATED POPULATION	% OF POPN. AGE 16-65 EARN $7000+	% OF POPN. ABLE TO WORK BUT UNEMPLOYED
ALBUQUERQUE AREA	48,152	21%	56%
STUDY COMMUNITY	2,899	21%	54%

*Source: BIA, Office of Financial Management: "Indian Service Population and Labor Force Estimates," September, 1984.

BEST COPY AVAILABLE

TABLE 8

10 Leading Causes of Death, 1976 - 1978*

CAUSES	STUDY COMMUNITY Rate (# cases)	AAIHS Rate	U.S. Rate
Accidents	341 (19)	158	50
Cancer	36 (2)	66	182
Heart Disease	143 (8)	66	334
Alcoholism	143 (8)	52	2
Cirrhosis	269 (15)	49	14
Suicide	54 (3)	30	13
Influenza and Pneumonia	18 (1)	26	27
Cerebrovascular Disease	72 (4)	23	84
Congen. Anomalies	0	19	6
Unknown or ill-defined	54 (3)	63	15
All other causes	323 (18)	152	
TOTALS	1454 (81)	703 (881 cases)	880

*Average annual death rate over 100,000 population.
1977 population of study community at 1,857; of Albuquerque Area at 41,772.

Source: AAIHS: Albuquerque Area Health Indicators 1976-1978.

BEST COPY AVAILABLE

TABLE 9

RATIO OF MORTALITY RATES:
STUDY COMMUNITY WITH AAIHS AND U.S.*

CAUSE OF DEATH	Rate Ratio Study Community/AAIHS	Rate Ratio Study Community/U.S.
Accidents	2.2	6.8
Cancer	0.5	0.2
Heart disease	2.2	0.4
Alcoholism	2.8	71.5
Cirrhosis	5.5	19.2
Suicide	1.8	4.2
Influenza and pneumonia	0.7	0.7
Cerebrovascular disease	3.1	0.9
ALL CAUSES	2.1	1.7

*See previous table for explanation of mortality rates.

BEST COPY AVAILABLE

HEALTH SERVICES DIVISION
Post Office Box 968
Santa Fe, New Mexico 87504-0968
Mary Lou Martinez, Director

TONEY ANAYA
Governor
FITZHUGH MULLAN, M.D.
Secretary
TEODORO "TED" GUAMBAÑA
Deputy Secretary
JOSEPH JOHNSON
Deputy Secretary

January 7, 1986

Chairman George Miller
Select Committee on Children,
Youth and Families
United States House of Representatives
Room H2-385
House Annex 2
Washington, D.C. 20515

Dear Chairman Miller:

The attached abstract of the Native American Adolescent Injury Prevention Project is being submitted as information to the Select Committee on Children, Youth and Families hearing in Albuquerque on January 10 on issues of Native American children, youth and families.

There is a critical need to reduce unintentional injuries and deaths occurring to Native American youth. In an effort to decrease these needless deaths, the New Mexico Health Services Division, Health and Environment Department has initiated this project. It is funded by the Department of Health and Human Services Division of Maternal and Child Health under the Special Projects of Regional and National Significance (SPRANS) Grant.

The Injury Control Program and Adolescent Health Program of the Health Services Division are directing the Project and are coordinating it with the Indian Health Service and tribal representatives.

Thank you for including this information in the hearing proceedings.

Yours truly,

Joyce DeVaney

Joyce DeVaney, MPH
Adolescent Health

JD:tjp

cc: Mary Lou Martinez, Director, Health Services Division
Jeffrey M. Davis, MD, MPH, Maternal & Child Health Bureau Chief
Ken Peterson, MPH, Injury Control Manager

EQUAL OPPORTUNITY EMPLOYER

BEST COPY AVAILABLE

NATIVE AMERICAN ADOLESCENT INJURY PREVENTION PROJECT

NEW MEXICO HEALTH AND ENVIRONMENT DEPARTMENT

ABSTRACT

This project addresses the problem of unintentional injuries among Indian adolescents in New Mexico and the Southwest. Injuries represent the leading cause of death for Native Americans with a death rate three and one-half times that of the United States average for the 15-24 year old age group. In New Mexico, motor vehicle causes account for 75 percent of all injury deaths among Native American teenagers.

This project establishes a descriptive data base on unintentional injuries among Native American youth in the Albuquerque and Navajo Areas of the Indian Health Service. In addition, an inventory of existing teen injury prevention materials is being generated. Student surveys will establish baseline data on knowledge, attitudes and behaviors relating to injury risks, injury prevention and injury occurrence as well as identifying teen attitudes about effective messages and approaches that influence positive health changes. These school-based surveys will be conducted in six communities, three intervention and three control communities. One intervention and one control community will be selected from each of the three tribal groups in New Mexico (Navajo, Apache & Pueblo) to determine comparative injury incidence and community and tribal receptivity to prevention strategies.

Five years of hospital outpatient and inpatient data is being collected retrospectively from Indian Health Service and will continue to be collected in the three years of the program. A ten percent sample of baseline and third year cases will be reviewed to solicit more specific information on etiology and circumstances of the injury. Data on unintentional injury deaths during this period is being obtained as well. Data needs and problems will be addressed throughout the project with the Indian Health Service to improve the existing data base on unintentional injuries and their circumstances.

Culturally-relevant prevention strategies on motor vehicle and other injuries will be generated and implemented by junior and senior high students in the target schools for use with their peers. Audiovisual productions, teen theater, and peer education have proven to be effective methodologies in New Mexico. The injuries to be targeted and the approaches to be utilized in this project will be based on student survey results. The prevention materials will be refined and marketed to other schools and communities in the southwest. In addition, a handbook summarizing and detailing these prevention strategies will be developed and disseminated to interested states and agencies. Seed money will be offered to schools and/or communities in the third year of the project to implement intensive injury prevention programs using the available materials and strategies.

BEST COPY AVAILABLE

THE EPISCOPAL DIOCESE OF THE RIO GRANDE
URBAN INDIAN MINISTRY

January 12, 1986

The Honorable George Miller, Chairman
House Select Committee on Children, Youth, and Families
Washington, D.C. 20515

JAN 16 1986

Dear Representative Miller:

Thank you for holding the recent hearings in Albuquerque on the problems of Native American families and youth. It struck me that most of the materials presented were in relation to the problems on the reservations. Having served in Navajoland for five years it is certainly clear to me that there are massive problems on the reservations, especially in relation to the dissolution of the family structures and the sense of hope and purpose in the youth.

The only concern about the hearing that I felt was that there seemed to be a suggestion that the youth should stay on the reservations and that means should be developed to keep them there. My concern is that this is all well and good - and I do feel that there is every reason to support Native Americans in their yearning to hold fast to their cultures and life styles and to show respect for these - but what I see happening is that the youth are NOT going to stay on the reservations, no matter what we do.

I have been asked by our church, local and national, to begin an Urban Indian Ministry in Albuquerque. In the six months that I have been involved with this on a part-time basis it has already become quite clear to me that the Navajo youth, in particular, are looking to the urban areas for their future. I go regularly to the Southwestern Indian Polytechnic Institute in Albuquerque, which serves tribes from all over the country, and every student and staff person I speak to indicates that Native American youth are seeking employment and their futures in the cities. Places like S.I.P.I. need support and encouragment to assist in the painful transition from reservation to urban society. One of the needs S.I.P.I. has is for married student housing and day care for the children of their students. It seems that this should be of concern to your committee.

It was good to hear that your committee would be open to receiving concerns for at least two weeks from the time of the hearings. This letter is submitted as such material.

In my work in Albuquerque I have been meeting with a group of Albuquerque Native Americans to assist in the planning for church-sponsored hearings on the urban Indian situation in Albuquerque. Already it is clear to me that urban Indians are lost in the shuffle. City, County, State, Tribe, and the Federal Government all look the other way in terms of their needs. The Navajo Tribal Chairman, apparently, has indicated some sensitivity to the growing urbanization. I will be happy to keep you informed as to these hearings and any reports that may issue from them.

I spoke briefly with Congressman Wheat of your committee at the end of the meeting and understand that you are just beginning. If it will be at all helpful, I will be glad to continue to keep in touch.

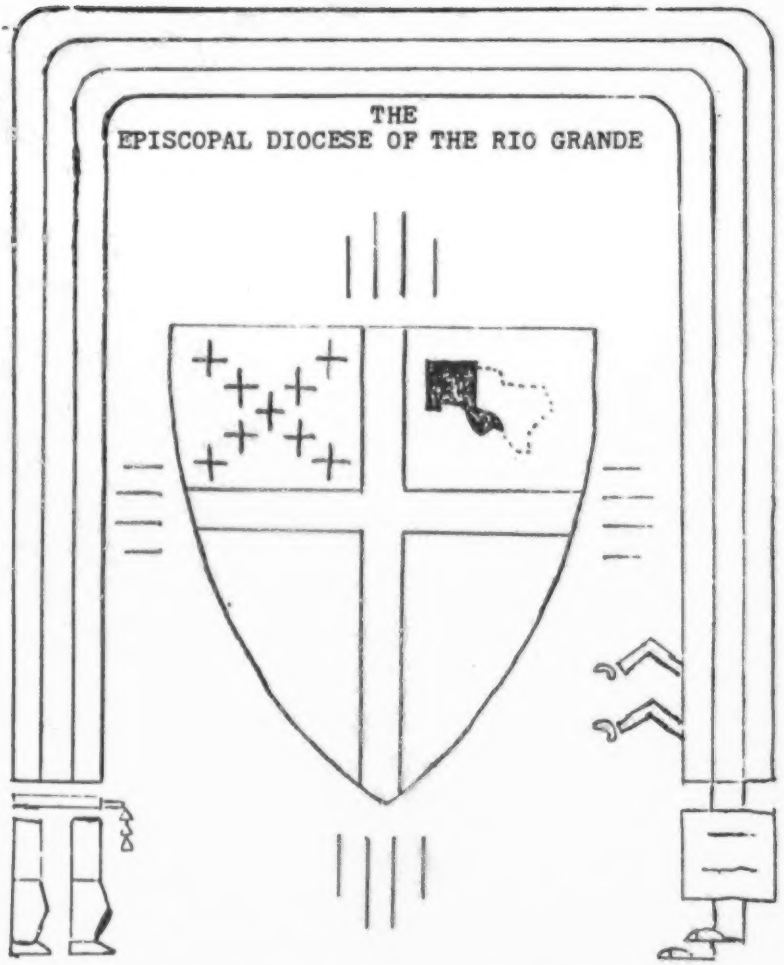
With all best wishes.

Sincerely,

Henry Bird

The Rev. Henry L. Bird
904 Leroy Place
Socorro, NM 87801

BEST COPY AVAILABLE



U R B A N I N D I A N P R O G R A M
4304 Carlisle, NE, Albuquerque, NM 87107
(505) 881-0636

The Rev. Henry L. Bird, Coordinator

The Urban Indian Program of the Episcopal Diocese of the Rio Grande is a new effort on the part of the Church to reach out and serve the growing population of Native Americans in the City of Albuquerque.

In cooperation with the agencies and institutions already providing services and facilities, the Church is looking forward to assisting in providing a "home-away-from-home" that respects and holds up the values of tribal culture and traditional religious expression. This Church feels that the Christian faith does not negate those human values that enable people of all sorts to relate to each other in respect and affection, and the Church wishes to function in a way that enables peoples of differing cultures to enrich each other.

The Episcopal Church is a Sacramental Church - or one that uses the elements of God's Creation with respect and a sense of mystery, wonder, and awe - and this Church seeks to offer Sacramental Worship which can be adapted to various cultural expressions.

It is hoped that worshipping communities will develop through this program and that, in cooperation with others, educational, health, legal, employment, housing, and other needs may be served.
Please call or write or talk to the Coordinator if you would like to work with us...

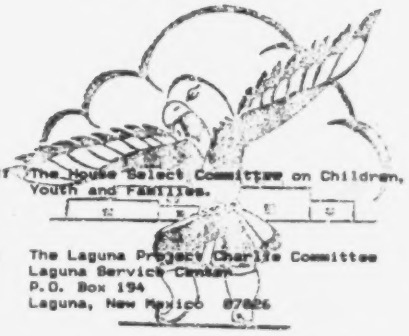
PUEBLO OF LAGUNA
P.O. BOX 194
LAGUNA, NEW MEXICO 87026

(505) 243-7818
(505) 552-6654
(505) 552-6655

TESTIMONY

ON PROJECT CHARLIE

AT THE LAGUNA RESERVATION



PREPARED FOR: The House Select Committee on Children, Youth and Families.

PREPARED BY: The Laguna Project Charlie Committee
Laguna Service Center
P.O. Box 194
Laguna, New Mexico 87026

DATE: January 10, 1986

BEST COPY AVAILABLE

TABLE OF CONTENTS:

Page

I. Introduction..... 3

II. History of Project Charlie on the Laguna Reservation.... 3

III. Program Methodology..... 4

IV. Program Evaluation..... 4

A. Overview of Objectives.

B. Method.

C. Summary of Teacher Survey Results.

D. Discussion.

V. Appendices..... 6

A. Preliminary Survey Instrument.

B. Letters Received From Parents on Project Charlie.

C. Letters Received From Pueblo of Laguna Tribal Administration.

D. Letters Received From School Administrators.

E. Letters Received From Affiliated Organizations.

BEST COPY AVAILABLE

I. INTRODUCTION:

In 1976, the orgins of Project Charlie began in Edina, Minn., as a community-based effort to combat the effects of chemical dependency and other drug related problems. The result was a substance abuse prevention program called Project Charlie (Chemical Abuse Resolution Lies in Education). The program objective is to promote the social and emotional growth of children and to discourage chemical use as a way to avoid problems.

II. HISTORY OF PROJECT CHARLIE ON THE LAGUNA RESERVATION:

Project Charlie was first introduced to the Laguna Elementary School in August 1984. A presentation was made to the school board, and with the school principal's support, Project Charlie was demonstrated to the teachers and to the Parent Teacher Organization (PTO).

During the first year, project instructors consisted of a school counselor, a community health nurse, a social worker and three counselors from the Laguna Service Center. Staff met weekly to review project curriculum and develop lesson plans for grades 2 thru 6. On October 23, 1984, weekly classes began and continued throughout the school year.

Parents, school staff and school board members were encouraged to observe classes. This support was necessary for the program to be effective as well as to support the motivation of the instructors. Continuous presentations to the PTO are important as a means of allowing community awareness and input.

During the PTO meeting in May 1985, parents responded positively to the program and endorsed it for the following school year. PTO has also requested more presentations to familarize parents with project terminology. Some community agencies have also expressed an interest in being involved in Project Charlie.

Assessment and follow-up procedures are in the initial stages of development and the results of a preliminary evaluation are provided in apendix E of this report. The focus of each component included in the program evaluation is to provided a measure of the success of Project Charlie.

BEST COPY AVAILABLE

III. PROGRAM METHODOLOGY:

The cirriculum developed for Project Charlie is written for elementary schools and is divided in two(2) major sections addressing the following factors:

1. Self esteem
2. Peer pressure
3. Healthy relationships
4. Decision making skills
5. Boredom and curiosity
6. Drug information

The primary section is designed for grades K-3 and intermediate for grades 4-6. "You are someone special" is the adopted theme of Project Charlie and is written on the board each time class is presented as a means to emphasise the critical aspect of self awareness.

The first and longest unit stresses personal awareness of strengths and capabilities and expression of basic feelings (e.g., mad, glad, afraid, ashamed, sad). Unit 2 - Relationships, helps children to identify qualities of friendship, encourages them to examine their values, the effect of peer pressure on their behavior and their relationship with their families, friends, and classmates. Unit 3 - Decision-making, encourages students to explore their personal values and learn to make decisions based on what they believe rather than on peer influences. Steps in making decisions are presented, as well as techniques in exploring alternative choices and their subsequent consequences.

The program emphasizes feeling good about yourself without sacrificing anyone else's well-being. Children are taught to respect themselves and others and to make healthy decisions. Project Charlie classes focus on communication and emphasizing the importance of listening.

Chemical use in society is presented in the intermediate section and is introduced to increase student awareness of the different uses of chemicals, the effect of advertising, peer pressure and societal acceptance of drug use and abuse and the exploration of alternatives, choices and their outcomes.

IV. PROGRAM EVALUATION:

A. Overview of Objectives:

The content of each section was designed to derive information from specific groups of people involved in Project Charlie. The primary objective of the evaluation was intended to obtain perspectives of teachers and parents on the success of Project Charlie as observed in the home and classroom.

BEST COPY AVAILABLE

B. Method:

Survey questions designed for the teacher survey focused on demonstrating the strengths and weakness of Project Charlie in the school. Specific items selected for evaluation directed attention to observations of students using Project Charlie rules and skills both in the classroom and outside the classroom. Parent questions assessed the understanding of program objectives and behavioral observations of the children in the home. Shown in Apendix A, are examples of the survey instruments used.

C. Summary of Teacher Survey Results:

Of the twelve(12) classrooms participating in the program (i.e., grades 2nd through 6th), eight(8) surveys were completed. The results of the teacher survey indicated Project Charlie rules are utlized by a majority of teachers to strengthen existing classroom rules. Other comments revealed teachers who include Project Charlie rules chose so as a way of providing a relaxed, non-threatening classroom atmosphere.

Behavioral changes in the classroom indicated students receiving skills in listening and communication has helped to reduce anxiety in teacher-student relationships. Students were reported to be less reluctant to ask for teacher assistance and were more responsive during classroom discussions. The majority of teachers surveyed reported the project as a positive appoach to education on social and intrapersonal skill development.

Negative results indicated differences among Project Charlie facilitors in manner of currculum delivery and ability to enhance student participation. In an isolated case, disciplinary problems observed during Project Charlie and regular class time were identified and compared. Project Charlie sessions were viewed as positive, however, behavior and attitudes did not appear to transfer onto the classroom setting.

D. Discussion:

Due to the stringent time limitations, very few parents were contacted for their involvement in the evaluation. Shown in Appendix B, are letters received from parents commenting on Project Charlie.

The overall results of this prelimiary survey indicated a general acceptance of Project Charlie by both parents and teachers. Most reported a full understanding of the program goals and objectives plus the long term benefits associated with substance abuse prevention. The program benefits are clearly seen in terms of quality assurance measures to be developed for identifiable improvements and suggested changes in curriculum. A need for periodic program review is revealed in this study inaddition to facilitator need for skills workshops on project techniques and delivery of classroom presentations.

BEST COPY AVAILABLE 279

APPENDIX A - PRELIMINARY SURVEY INSTRUMENT:

LAGUNA SERVICE CENTER

PROJECT CHARLIE
AT THE LAGUNA ELEMENTARY SCHOOL

QUESTIONAIRE FOR TEACHERS

Please provide comments on the following questions concerning project CHarlie in your classroom. The information provided is intended to be included as part of our testimony to the House Select Committee on Children, Youth and Families on January 10, 1986, in support of the project here on the Laguna reservation. Your help in this matter is valued and very important.

Directions: Write a summary on a separate sheet of paper. Please provide your signature.

1. Project Charlie Rules:

   a. Do you observe the students in your classroom using the rules of Project Charlie? When and which rules are used most often?

   b. Do you observe the students in your classroom using the rules of Project Charlie during play time? Identify which rules?

   c. How have the rules of Project Charlie changed the atmosphere of your classroom?

2. Behavior Changes:

   a. Do you observe students using the skills of listening and communication learned in Project Charlie? If so, in what manner has this enhanced positive interaction between you and the student(s)?

   b. What teaching techniques or methods currently used in your classroom appear to be assisted by the learning processes provided through Project Charlie lessions? How is it beneficial?

   c. Do you believe the lessons provided by Project CHarlie have provided a more safe environment to allow students to explore themselves and to share feelings with you as a teacher?

4. Are you fully aware of the intentions of Project CHarlie? Do you feel Project Charlie is necessary?

BEST COPY AVAILABLE

LAGUNA SERVICE CENTER

PROJECT CHARLIE
AT THE LAGUNA ELEMENTARY SCHOOL

QUESTIONAIRE FOR PARENTS

Please provide comments on the following questions concerning project CHarlie at the Laguna Elementary School. The information provided is intended to be included as part of our testimony to the House Select Committee on Children, Youth and Families on January 10, 1986, in support of the project here on the Laguna reservation. Your help in this matter is valued and very important.

Directions: Write a summary on a separate sheet of paper. Please provide your signature.

1. What have you learned from your child about Project CHarlie?

2. What is the best aspect of Project Charlie in your opinion?

3. Does you child talk to other children in your household about what they have learned in Project Charlie? If so, please describe:

4. Are you fully aware of the intentions of Project CHarlie? Do you feel Project Charlie is necessary?

5. Would you like to learn more about Project Charlie?

1

BEST COPY AVAILABLE

APPENDIX B - LETTERS FROM PARENTS ON PROJECT CHARLIE:

January 08, 1986

Honorable Congressman George Miller
Chairman
House Select Committee on Children, Youth & Families
Room 385
House Annex #2
Washington, D.C. 20515

Dear Chairman,

Today our Laguna children are growing up in a society which is greatly influenced by the pressures of people form the outside, attitudes and ideals which come from their T.V. viewing, newspapers, magazines. Through these, they are more susceptible to the ills of today's society.

We as parents and educators need to help our children in overcoming these influences and to help them develop a positive selfconcept.

Project Charlie at Laguna Elementary School, is one positive way that the children are being taught an individual's role as a citizen and as a family member. They are being taught to understand themselves and others by learning how to express their feelings about different issues which concern them.

During the 1984-1985 school year, I made an effort to attend the Project Charlie classes in which my daughter was a participant. Through these sessions, I was able to gain more knowledge about my daughter and how she felt about them. These were issues which we never talked about at home.

I encourage parents to observe these classes because then they will be able to reinforce what is being taught and also to gain a greater insight into their child.

Sincerely,

Cecelia M. Lucero

Cecelia M. Lucero
PTO President
Laguna Elementary School
Laguna, New Mexico

BEST COPY AVAILABLE

PUEBLO OF LAGUNA
P.O. BOX 194
LAGUNA, NEW MEXICO 87026

Office of:
The Governor
The Secretary
The Treasurer

(505) 243-7816
(505) 552-6654
(505) 552-6655

January 09, 1986

Laguna Service Center
P.O. Box 194
Old Laguna, New Mexico 87026

ATTN: Arlene Alonzo

Dear Ms. Alonzo:

First, I would like to express my graditude to the Service Centers participation in the pilot project. Project Charlie has been very worthwhile to those children who receive it in their classrooms. I know it means something to my son. Also, it has allowed the Laguna Elementary School to become more aware of those children who may be experiencing a difficult family life. Another important point is that it reminds us all as parents to provide more support, praise and recognition to our children for their efforts.

I personally commend everyone who is involved in this project and hope it will continue is this community. I fully support you all!

Sincerely,

PUEBLO OF LAGUNA

Marlys Hubbard

Marlys Hubbard, Family Counselor
Laguna Family Shelter Program

MH/kl

BEST COPY AVAILABLE

RE: Project Charlie

Project Charlie is something my daughter looks forward to each week. She enjoys the classes and those presenting the Project. Since starting Project Charlie she has learne she is not the only one with problems, not necessarily with understanding the problems of drinking, drugs, etc., but with her own feelings. At the beginning of school she was teased by her classmates for being to "big" for her age and wouldn't play with her because of this. She is able to understand her feelings and knows she is not the only person whose feelings has been hurt by others.

She is able to express herself more than before and this has been helpful to her with her school work. She is able to talk with her brother and not be treated like a little kid by him.

I myself would like more information on Project Charlie, but do feel it is necessary because it has been helpful to my daughter. Starting Project Charlie at the elementary level is a good idea in helpling the children to deal with what is going on around them, most especially at home. For other children like my daughter or any child that feels they are the only ones with problems at home or at school, Project Charlie will be a big factor in their lives.

I would like to express my gratitude to the people involved with Project Charlie at the Laguna Elementary School.

Susie M. Kasero

BEST COPY AVAILABLE

APPENDIX C - LETTERS RECEIVED FROM PUEBLO OF LAGUNA TRIBAL ADMINISTRATION:

PUEBLO OF LAGUNA
P.O. BOX 194
LAGUNA, NEW MEXICO 87026

Office of:
The Governor (505) 243-3718
The Secretary (505) 552-6651
The Treasurer (505) 552-6652

January 6, 1986

Honorable Congressman George Miller
Chairman
House Select Committee on Children, Youth & Families
Room 385
House Annex #2
Washington, D.C. 20515

Dear Chairman,

As Governor, I am very pleased to welcome members of the House Select Committee on Children, Youth and Families to the Pueblo of Laguna. I am aware of the opportunity to present testimony on issues affecting Indian families living on reservations at the scheduled hearing in Albuquerque, NM, on January 10, 1986.

Within the tribal structure of our Pueblo, exists the Division of Community Services which is a component directly designated to address the social needs of the Laguna community. A special project was introduced two (2) years ago which has made significant strides toward instituting a viable approach to alleviating problems affecting elementary age children and their families. The program is called "Project Charlie," a substance abuse prevention program for elementary school children. The project is a nationally recognized prevention program now being implemented in hundreds of schools and communities throughout the United States.

Currently coordinated by the Laguna Service Center, the purpose of the project is to promote the social and emotional growth of children and to discourage chemical use as a way to avoid problems. The Pueblo of Laguna acknowledges the success of the project and endorses the expansion to the Laguna Acoma Junior-Senior High School youth populations of our reservation. This endorsement is a product of the overwhelming acceptance by parents, teachers, administrators, school board members and tribal officials.

The Laguna Project began as a pilot program in 1984. Since that time, the Laguna concept has been accepted by Indian Health Service to the point that the Laguna Program is now making presentations to other IHS Alcoholism Program Directors. In conjunction with these presentations, Project Charlie coordinators are providing consultation to other programs and agencies, i.e., Isleta Elementary School, Thoreau Alcoholism Program, and Zuni Elementary School.

BEST COPY AVAILABLE

Because the Project Charlie Program has contributed greatly to the welfare of children, youth and families on our reservation, this obviously demonstrates the great amount of time and effort put forth by the Laguna Project Charlie staff. It is for this reason that we feel more time and attention should be given by the Select Committee to the Program.

Sincerely,

PUEBLO OF LAGUNA

Chester T. Fernando
Governor

BEST COPY AVAILABLE

PUEBLO OF LAGUNA
P.O. BOX 194
LAGUNA, NEW MEXICO 87026

Office of
The Governor
The Secretary
The Treasurer

(505) 243-7818
(505) 552-6654
(505) 552-6655

January 09, 1986

Honorable Congressman George Miller
Chairman
House Select Committee on Children, Youth & Families
Room 385
House Annex 2
Washington, DC 20515

Dear Congressman Miller:

As the Director of the Pueblo of Laguna's Division of Community Services, I wish to express my support of the Laguna Project Charlie.

The program has been functioning successfully for two years at the Laguna Elementary School. Presently it is the only on-going Project Charlie Program in the state of New Mexico. Additionally, with the planned expansion of the program into the Laguna Acoma Junior-Senior High School this year, this will be only the second program nationwide to have expanded the curriculum to meet the needs of the adolescent population.

The focus of the program is to build the self esteem of children through numerous various curriculums. The children, teachers and parents regularly praise the program and its value.

The original program did not incorporate an evaluation component making actual results difficult to measure. The Laguna Program is presently developing an evaluation component enabling the facilitators and teachers to gauge and report measureable changes within the children.

The Laguna Project Charlie Program has appropriately adapted the curriculum to meet the needs of the reservation children. Because of the incorporated changes, the program has become extremely attractive to other Pueblos around Laguna. As a result, the Laguna Program has provided technical assistance to Zuni, Santa Clara, Santo Domingo and Isleta Pueblos, assisting them in starting their own programs.

The Laguna Project Charlie Program has been extremely successful on the reservation. Students, teachers, parents and facilitators are very enthused about the scope and nature of this program. It is a positive step towards enhancing the self value of the Pueblo's youth while allowing them the freedom to make their own, educated decisions. Present and future generations of Lagunas shall benefit from the rewards reaped from this program.

Sincerely,

PUEBLO OF LAGUNA

Sue Forster-Cox

Sue Forster-Cox, Acting Division Manager
of Community Services

BEST COPY AVAILABLE

APPENDIX D - LETTERS RECEIVED FROM SCHOOL ADMINISTRATORS:

Rep. Bill Richardson
District 3
State of New Mexico

January 7,1986

Mr. Richardson:

It is my understanding that a Select Committee of the House of Representatives will make a visit to the "Acoma-Canoncito-Laguna Teen Center" here on the Laguna Indian reservation in New Mexico soon. I want to request that the Committee members make a visit to the Laguna Elementary School as well.

Members of the Social Services community here in Laguna give weekly presentations to the students in the areas of social and emotional growth. The working inter-action with the students has been termed "Project Charlie". Project Charlie has seen alot of success with the students in that it helps the student to begin to learn to deal with the continuous development of the student at an early age. The student begins to see that he/she is an important individual in the world and as a result confidence and the determination to succeed in life are instilled in the student. Learning to interact with others and positive decision making in dealing with drugs and home strife are a few other results of Project Charlie.

On the Native American Indian reservations there is a high rate of Suicide and alot of the problem is a result of alcohol and drugs. Education in this area cannot be conducted at too early an age. Project Charlie provides that type of education. As a concerned Parent I will give my support to programs that assist children in making positive decisions about their personal well being - both physically and mentally.

The Laguna Elementary School Board gave it's approval for Project Charlie to begin in the classrooms of Laguna Elementary and I feel it was one of the wisest decisions the Board members ever made. Committee members, Lawmakers and anyone working in the best interest of "the people" should take a look at Project Charlie it is a program that sees results.

Sincerely,

Michael P. Sarracino, Vice-President
Laguna Elementary School Board
P.O. Box 191
Laguna, New Mexico 87026

BEST COPY AVAILABLE

January 7, 1986

Hon. Willian Richardson
Congressional District #2
County Courthouse
Gallup, N.M.

Dear Sir:

It has come to my attention that there will be a congressional select committee that will be visiting the Pueblo of Laguna to look at certain tribal programs. It has also come to my attention that the program on drug and alcohol abuse called "Project Charlie" has been deleted from the visit in favor of visiting the "Teen Center", which is not a tribal project administered by the Pueblo of Laguna.

At this time I would like to write this letter in support of the "Project Charlie" program because of the progress that has been made since its inclusion into the curriculum at the Laguna Elementary School. Since I am the director of a program that deals with public school students I feel like the continuation of this program into the junior high and high school in our community is going to be a very positive step in solving the drug and alcohol problems we encounter. Those students that have been involved in Project Charlie have received very good information and have also been given close attention in what they may feel is a personal problem. It is my opinion that the Teen Center can not offer the same type of information and help since it is limited in its scope and is under staffed.

I am also a member of the Grants-Cibola County School District Board of Education and a former teacher. It is very important to me that there be some sort of system set up showing goals and direction for learning especially in an area of social concern. Project Charlie has this and the Teen Center has not, this is my opinion and mine only that the Project Charlie program should be included in the visit by the select committee.

Sincerely Yours,

PUEBLO OF LAGUNA

Joseph L. Shunkamolah, Director
Johnson-O'Malley Program

BEST COPY AVAILABLE

APPENDIX E - LETTERS RECEIVED FROM AFFILIATED ORGANIZATIONS:

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
PHS Indian Hospital
801 Vassar Drive, N.E.
Albuquerque, New Mexico 87106

January 9, 1986

Congressman George Miller
Chairperson of House Select Committee on
Children, Youth and Families

It is with great enthusiasm that I submit this testimony of support for the "Project CHARLIE" program at the Laguna Elementary School.

My involvement with Project CHARLIE began at the Laguna Elementary School after receiving training for the project at Edina, Minnesota in the fall of 1983.

After much support and assistance from the school counselor, the project CHARLIE program was initiated by using staff from the school, Acoma-Canoncito-Laguna Hospital, and the Laguna Alcoholism-Mental Health program.

As with most new programs, there was some skepticism as to the effectiveness of a chemical prevention program, especially during classroom time.

I am glad to testify that with much planning and credit to the facilitators, project CHARLIE became widely accepted, not only by the teachers and students, but the Laguna community as well. There have been numerous instances that not only I, but the facilitators have been complimented by parents for the Project CHARLIE program and the noticeable changes in the students' attitudes and behaviors.

The Project CHARLIE program is now in its' second year at the Laguna Elementary School, continuing to receive positive feedback regarding the impact on the students' behaviors and community support.

The program has become so well received in Laguna that the local high school also wants to incorporate the program someway with their high school students. Not only has the Laguna community accepted the project, but many other Indian communities have received the training and have begun to implement the curriculum in their local schools. One such community, Zia Pueblo, which I have been involved with has begun the program in late December 1985.

BEST COPY AVAILABLE

The Project CHARLIE program at the Laguna Elementary school has served as an example to other Indian communities and schools that a program can be effective in building self-esteem, relationships, and decision-making skills without destroying cultural values and customs, but enhancing those characteristics without chemical abuse.

Although statistics will not be readily available regarding the impact on chemical abuse by our present students, current information from the teachers and parents show a definite change in the students' behavior patterns and attitudes toward chemical abuse since Project CHARLIE's inception. Another important characteristic of the Laguna Project CHARLIE program is the number of requests for presentations to groups, schools, communities and alcoholism programs, which certainly substantiates its validity.

In conclusion, I believe Project CHARLIE is a program that can have a long-range impact on the amount of chemical abuse in the Indian communities, while simultaneously building positive social skills for productive Indian people in the Anglo and Indian societies without losing their Indian identity and/or cultural characteristics. Also, I believe as professionals interested in helping Indian communities implement new strategies for the rising chemical abuse problem, we must break the cycle by prevention (before the problem), rather than after the problem. The Laguna community has taken this initial step which I commend them for by their utilization of Project CHARLIE and their use of local community providers as facilitators.

Respectfully submitted,

David D. Atkins, MSW
Clinical Social Worker
Phone: 505-766-2930

BEST COPY AVAILABLE

January 9, 1986

Dear Congressman Miller:

I am taking the time to write to you today in hopes of drawing your attention to a special drug and alcohol abuse prevention program called PROJECT CHARLIE currently being provided by community service counselors to the children at Laguna Elementary School on the Laguna Pueblo Reservation.

The Project Charlie program evolved through the primary effort of our Indian health service social worker, who had attended a Project Charlie workshop and received hands on training in implementing the curriculum, and the determined efforts of myself, as a guidance counselor for 465 elementary school children, many of whose lives had been touched by the abuse of alcohol in one way or another. With the willingness and community commitment of the Alcohol counselors from Laguna service center and the local community health nurse we were able to overcome scheduling conflicts and feelings of skepticism in implementing Project Charlie on a weekly basis to compliment the curriculum of each classroom grades 2 through 6.

Throughout the school year of 1984-1985 the community service center counselors, the local community health nurse, the Indian Health service social worker and myself conducted within the regular classroom, Project Charlie activities that focused on self-awareness, relationship building, decision making. The outcome of student involvement in these activities is to promote and nurture the development of self-understanding, enhancement of the students positive qualities, the ability for the student to communicate their feelings effectively and to feel good enough about themselves as special people to be able to make appropriate choices when faced with decisions that could have a negative effect on their life.

Project Charlie has special significance at Laguna because it has served as a catalyst in bringing and involving local community counselors and resource people into the school, where the children can learn to know them as role-models, helping individuals and can become familiar with community programs they may one day need the assistance of.

I have seen such positive growth in our students since their participation in Project Charlie activities, shy children volunteering to share an assigned activity with classmates, children listening and responding to each other in offering ideas in problem solving and children reminding others that we are special and deserve to be treated with respect. Even parents have commented on their children sharing their feelings with them and showing a renewed enthusiasm for school and behaving as a "special person."

BEST COPY AVAILABLE

It has been an exciting experience to witness the growth of the community alcoholism counselors, who by profession are not educators, feel belief in the children enough to motivate them to enter the classroom, promote and direct the activities and begin to build relationships with the children themselves. I have watched them become more confident and self-reliant in their lessons and was able to leave Laguna Elementary school knowing Project Charlie would continue as an integrated part of the curriculum.

I hope in your future endeavors of visiting communities to observe or recognize community programs, that you give consideration to acknowledging the counselors at Laguna who are involved in working with Project Charlie. Their commitment and involvement with the children of their community truly represents the spirit of cooperation and the knowledge that the children are the future.

Sincerely,

Lucinda Sanchez
Assistant Director, Self-Help Program

Futures for Children
805 Tijeras NW
Albuquerque, NM 87102

BEST COPY AVAILABLE